

# **Governor Kaine's Commission on Sexual Violence**

## **Executive Summary of Public Input Sessions**

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# Governor Kaine's Commission on Sexual Violence

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## Summary of Public Input Sessions

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### Background

Four public input sessions conducted in late January and early February, 2007 in various regions of the state gathered information and recommendations for consideration by the Commission on Sexual Violence and its three committees.

Members of the commission's Core Work Group provided Virginia Commonwealth University (VCU) staff with e-mail contact addresses for their key partners and organizations. More than 2,000 e-mail invitations were sent and recipients were encouraged to share the invitation with customers, staff and partners. An invitation was also posted on the Secretary of Public Safety's web site. Commission members attended as observers at all four sessions.

Table One provides a summary of attendance and the diversity of organizations and interests represented across the regions.

**Table One: Summary of Session Attendance**

Category	Region				Total
	Northern	Southwest	Central	Tidewater	
Alliances & Councils	1	1	5	4	11
Citizens	0	2	0	3	5
Crisis Centers	7	13	8	15	43
Health Care	3	11	7	9	30
Higher Education	2	0	3	4	9
Human Services Providers	27	28	16	7	78
Judicial System	0	3	6	7	16
Law Enforcement	3	3	5	5	16
Local Government	0	2	0	0	2
Military	0	0	0	5	5
State Agencies	2	1	7	5	15
<b>Total Attendees</b>	<b>45</b>	<b>64</b>	<b>57</b>	<b>64</b>	<b>230</b>

## Session Overview

Each participant received a handout explaining the intent and format of the session (Appendix A). Participants also received a copy of Governor Kaine's Executive Order 19 and a list of commission members.

To maximize active participation by all attendees, staff from Virginia Commonwealth University's Office of Public Policy Training facilitated the sessions. The intent of the input sessions was to solicit responses to the following three questions:

What is currently working well to help prevent instances of sexual violence and what are the best practices in place for intervention and treatment for victims and prosecution of offenders?

What are the most critical barriers to reducing instances of sexual violence, responding effectively to and providing treatment for victims, and effectively and investigating and prosecuting cases?

Recommendations for future action in the areas of prevention, intervention and treatment for victims and criminal justice system response.

Participants worked in small groups to answer to all three questions. Comments were recorded on flip charts.

Upon completion of the sessions, all comments were transcribed and grouped by VCU staff into similar categories to identify key messages. There are a number of key messages that were consistently mentioned across all four input sessions. These are organized under four categories and summarized below:

- Crosscutting Issues
- Prevention
- Intervention and Treatment
- Criminal Justice System

## Crosscutting Issues

### Communication and Collaboration

Communities and regions that utilize coordinating councils, sexual violence task forces or other mechanisms that bring professionals together on a consistent, regular basis report to have better results in preventing and responding to sexual violence. Such mechanisms facilitate sharing of information and coordination of responses.

Sexual Assault Response Teams (SART) or Multidisciplinary Teams (MDT) improve the ability of communities to effectively respond to victims of sexual violence. Team members typically include police officers, prosecutors, medical personnel, emergency responders, therapists, victim advocates, social service employees and other service

providers. Such teams enhance the development of a coordinated response for each victim, helping to identify and obtain needed services and assistance.

The absence of coordinating councils, task forces, SARTs and MDTs contributes to the lack of consistent and effective responses in some communities. For more information on this issue reference the Intervention and Treatment section.

## **Prevention**

### **Secondary Education Programs**

Sexual violence education programs provided in public schools are cited as effective prevention practices. Frequently mentioned programs for younger children include *Good Touch, Bad Touch* and *Hugs and Kisses*. Programs that educate both males and females and address developmentally appropriate issues, such as appropriate attitudes towards the opposite gender, acquaintance rape, are mentioned as best practices.

Numerous participants indicate that prevention education programs are not available in all public schools. Contributing factors cited for the reduction or absence of sexual violence prevention programs include absence of a clear link to Standards of Learning (SOL) requirements, lack of support from school administrators and parents and a general reluctance to provide information relating to human sexuality.

The need to increase sexual violence prevention education in secondary schools is endorsed by participants in all sessions. Programs are recommended at the K-12 levels ranging from instruction regarding inappropriate touching for young children to ways of preventing date rape for older students.

### **Higher Education and Military Facilities**

Numerous sexual violence prevention and awareness programs are available on the campuses of community colleges and public and private colleges and universities in Virginia. Prevention programs are also present on many military bases. The design of these programs reaches out to young adults to help them understand their role in preventing sexual violence and appropriate responses to victims.

Participants recommend that these programs be strengthened and expanded to reach more students and military personnel. Programs designed and provided for both males and females are essential. It is also recommended that campuses have dedicated and appropriately trained personnel to address sexual violence issues.

### **Public Awareness**

Participants indicate the general public is not sufficiently aware of how to prevent sexual violence and respond appropriately to victims. Cited factors include a reluctance to publicly discuss sexual behavior and a denial that the problem exists in their community.

A coordinated statewide multimedia public education campaign is recommended to help raise awareness about sexual violence issues. A general education campaign should include messages regarding the relationship between domestic and sexual violence as well as help change attitudes that violence is acceptable. The campaign should also include messages designed to reach children and youth, parents, young adults and other segments of the society that might be at most risk.

## **Criminal Justice**

### **Investigation of Reports of Sexual Violence**

The way incidents of sexual violence are investigated by law enforcement varies among localities. Communities that received high marks for the way they conducted investigations had police/sheriff's departments that had specially trained individuals, usually assigned to a special unit, responsible for the investigation.

We heard from a number of individuals whose experience was less than positive. A theme common to all four regions, more pronounced in some than others, was that law enforcement personnel often appeared to "blame" the victim for the incident. This occurred most often if the alleged perpetrator was known to the victim. "Victim-blaming" also appeared when the complainant had used alcohol or other drugs prior to the sexual assault.

There were reports of some localities in which police would not investigate a sexual violence report if the victim had used alcohol or more frequently if illegal drugs were involved. The use of polygraph tests on victims by law enforcement to "check out their story" before a full investigation was undertaken was also reported.

There appeared to be consensus among the input sessions that there needed to be standardized, mandated training for law enforcement officers, at the very least on interviewing victims, rape trauma syndrome, and acquaintance rape. This training should be conducted for patrol officers, new recruits, and other first responders. Advanced training should be ongoing for those who are assigned to investigate sex crimes.

There were several groups who recommended that there be consistent, statewide protocols and procedures for how incidents of sexual violence should be investigated. This would minimize the disparities and differences in how victims are treated in the Commonwealth.

### **Sexual Assault Nurse Examiners (SANE) and Forensic Nurse Examiners (FNE)**

One of the most consistent themes heard in the input sessions were the overwhelmingly positive comments about the Sexual Assault Nurse Examiners (SANE) and Forensic Nurse Examiners (FNE) programs. These specially trained nurses conduct the medical exam of a victim in a forensically sound way, collecting and preserving evidence that can be used by law enforcement. These programs are most often found in large urban

hospitals with active Emergency Rooms. Some SANE and FNE nurses are 24/7 and others are “on-call”.

Some programs have a victim advocate on-call who can be present to support a victim through the exam. Others do not. The lack of standardized protocols in hospitals was reported as a barrier to consistently effective services. In hospitals that do not have an in-house advocate, the Health Insurance Portability and Accountability Act (HIPAA) has been a barrier to service. HIPAA regulations do not allow hospital staff to contact a support person/advocate at Sexual Assault Centers or Victim/Witness Programs without the victim’s express permission.

A recommendation offered is that Virginia should seek an exception to HIPAA so that medical staff can call a victim advocate to the hospital to support a victim of sexual violence.

Another recommendation that was overwhelmingly supported was increased funding for SANE/FNE programs so that victims in rural areas would have easier access to this service.

### **Physical Evidence Recovery Kits (PERK)**

At each of the input sessions, the issue of PERKs was discussed. These evidence kits are sometimes critical to the successful prosecution of a sex crime. However, in order for a PERK to be completed and paid for by the Commonwealth, a victim must agree to contact law enforcement and prosecute the offender at the time of the exam. If a victim does not agree to such a commitment, he/she must pay for the PERK themselves. Many participants at the input sessions felt that having to make this kind of decision was too much to require of a victim during a time of crisis.

A recommendation was made several times to either allow or mandate that the state pay for PERKs without the victim committing to prosecution at the time of the exam.

At every public hearing, we heard comments that it often takes months to receive the results of PERK tests. The delays in receiving the PERK test results then leads to a delay in the investigation or prosecution of a case. The overwhelming recommendation was to reduce the time it takes for the state forensic lab to process PERK and DNA tests. Session participants specifically suggested that the state hire more forensic lab technicians.

### **Reporting and Under-Reporting Of Sexual Violence**

In Virginia there is a 24 hour statewide hotline and many local hotlines available for the reporting of incidents of sexual violence. A hotline is often the first place to receive a report of sexual violence. Victims can receive information, support, crisis intervention and referrals to needed short and long-term services. Although hotlines are one of the strengths of Virginia’s system, lack of staffing due to funding, do not allow all of the local hotlines to be staffed 24/7. This can delay reporting and receiving of available services.

Although Virginia has a good system through which sexual violence can be reported, there were concerns by some participants that incidents of sexual violence go unreported for a variety of reasons. Among one of the reasons cited was the fear of a negative response by the community and criminal justice system. This belief is directly related to the previously stated issue of “victim-blaming”. It is not uncommon for victims to already feel a variety of negative emotions such as shame, fear, embarrassment and self-recrimination. These feelings are often amplified in some communities and cultures.

Some victims do not report sexual violence for fear of reprisal or of being stigmatized by their family and community. Prison inmates and residents of other institutions often are revictimized if they report.

There are those victims who do not report sexual violence for other reasons. The mentally ill, immigrants –legal and illegal, those who do not speak English, and victims of same sex violence often find the barriers to reporting too high to overcome. At the input sessions we received more information about these barriers than any recommended solutions.

### **Mandatory Reporting**

Comments about the mandatory reporting of sexual violence were not clear whether they referred to reporting to law enforcement or to Child Protective Services. Some people felt strongly that there should be enforcement of mandatory reporting by schools, churches, and other organizations so that offenders could not just resign from one position and then return to another position in the same or similar organization.

Others felt that mandatory reporting could discourage reporting by children and youth to a trusted authority figure, i.e. guidance counselor, for fear of having it reported to authorities or their parents. This could leave a young victim feeling that there was no one to talk with and from whom they could receive support.

### **Prosecution**

The comments that we heard concerning the prosecution of sexual violence offenders were very similar to the comments about the investigation of alleged perpetrators. Localities that have specially trained prosecutors who have sexual assault cases as their sole or major responsibility, were perceived to be more effective and more sensitive to victims.

The model of vertical prosecution, in which the same prosecutor handles the case from the first hearing through the final hearing, from General District Court through Circuit Court, was reported to be the most victim-friendly.

There were comments made in several groups that prosecutors do not want to go forward with “unwinnable” cases. Cases in which there was no physical evidence, or in which the victim had used alcohol or other drugs were often deemed “unwinnable”. Similar to comments about law enforcement, some people felt that there is a “victim-

blaming” attitude among some prosecutors, especially in cases in which the victim knew the perpetrator.

There was some discussion about how data was collected and reported by Commonwealth Attorneys. A suggestion that came forward was that there should be a report card on prosecution – reporting how many cases were reported, charged, prosecuted and the outcome.

Several recommendations were consistent across sessions. One recommendation was that trials be scheduled as close to the arrest as possible and not be allowed to be dragged out with multiple continuances. Another was that there should be timely notification of court hearings or continuances to victims and witnesses.

Development of “Court Watch” programs, similar to those in place for cases of domestic violence and drunk driving, was also recommended.

### **Training for Prosecutors**

We heard a number of comments that sexual violence cases were often assigned to the newest, least experienced prosecutors. One participant said in her locality cases were assigned to whoever “got the short straw”. A consistently given recommendation was that prosecutors receive specialized training in handling cases of sexual violence, including information on the dynamics of familial sexual assault.

## **Intervention and Treatment**

### **Sexual Assault Crisis Centers**

The system of Sexual Assault Crisis Centers appears to be the heart of service delivery for victims of sexual violence. They often provide support groups for victims, for adult survivors of sexual abuse, referrals to specialized services, accompaniment through the legal system, and advocacy for individual clients. It is that consistent one-to-one relationship with an advocate that seems to be most important for a victim as they go through the criminal justice and healing process.

The hotlines referenced earlier are usually housed and staffed by the sexual assault centers. Staff members from these centers often also serve on local multidisciplinary teams that address local policies, protocols, and system issues.

We did hear that inconsistencies exist in the quality, hours, and services provided. As one might expect, programs in rural areas were less likely to provide as many services or be staffed for as many hours as centers in more populated areas. Several people recommended that there be a set of standardized protocols and level of services required for centers.

One frequent recommendation to correct these inconsistencies was to increase the funding of the sexual assault centers. There were recommendations to provide

programs that would do outreach into underserved populations such as the elderly, immigrants, and males.

### **Victim/Witness Programs**

In the public input sessions, Victim/Witness (V/W) programs were often mentioned alongside the Sexual Assault Centers. Victim/Witness programs provide support to victims through the investigation and trial by assisting with one-to one support, education on the legal system, transportation, notification of court dates, and assistance with receiving help from the Criminal Injuries Compensation Fund (CICF).

There were comments about the V/W programs similar to those about the Sexual Assault Centers. These included the lack of standardized services, hours and functions, and even the lack of services in some areas.

We frequently heard that there should be a uniform set of services and standards across the Commonwealth so that victims in all localities had access to the same level of services.

### **Child Advocacy Centers**

Child Advocacy Centers exist in several of Virginia's large, urban areas. These centers are "one-stop" operations for the investigation and treatment of child victims of sexual assault. They generally encompass medical exams, forensic interviews with law enforcement and child protective services and follow up treatment in a child-friendly environment. Many participants praised these centers as the ideal way to handle cases of child sexual assault.

Overwhelmingly, the creation of more Child Advocacy Centers was among the recommendations at each of the four public input sessions. These centers are models of the multidisciplinary team approach that is discussed earlier under crosscutting issues.

### **Hotlines**

In the section "Reporting and Under-reporting of sexual violence" there is brief mention of the services provided. These Sexual Assault Hotlines are usually housed and staffed by the Sexual Assault Resource Centers. They are often the first point of contact between a victim and the "system". Hotline staff provide crisis intervention, support and referral services. They play a critical role in assisting victims with finding the resources and help they need.

As with other services, the hours, the level and training of staff are inconsistent around the state. There were no recommendations specific as to Sexual Assault Hotlines apart from the ones related to the Sexual Assault Centers.

### **Transportation**

Lack of transportation for victims to hospitals, counseling, and other services continue to be a challenge in Virginia. The problem is found largely, but not exclusively, in rural

areas. Victim/Witness and Sexual Assault Centers staff and volunteers appear to be the primary providers of transportation for those victims without their own transportation.

Increased funding for these programs was the sole recommendation to alleviate this problem.

# **Governor Kaine's Commission on Sexual Violence**

## **Addendum to Summary Report of Public Input Sessions**

**March 2007**

Prepared by:  
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## **Governor Kaine's Commission on Sexual Violence**

### **Northern Virginia Input Session Summary**

#### **Best Practices**

##### **Public education programs in schools and the community**

- Training peer educators in schools to provide outreach and education to fellow students.
- Risk reduction and sexual violence education both pre and post assault.
- Prevention education in schools.
- Programs that educate boys as well as girls.
- *Child First Program* – child programs such as *Good Touch, Bad Touch* and *Hugs and Kisses*. This increases public awareness and education. Internet safety programs give kids and parents skills to protect themselves on the internet.
- Community Outreach – Prevention Specialist helps facilitate access to services.
- Select houses of worship addressing sexual violence.

##### **Timely, effective prosecution of offenders and post-conviction monitoring**

- Trainings for judges about sexual violence.
- Three strikes severity.
- Adequate sentencing to prevent re-offending.
- Enforcing sex offender registry regulations, catching parole violations, physical visits, charging for violations.
- Recognition and consequences of stalking and bodily harm – issuance of protective orders.
- Police officers and School Resource Officers to identify at-risk offenders and victims.
- Interdisciplinary team of professionals including commonwealth attorney who specializes in sexual assault/child sexual abuse. Specialized police investigators with access to training (i.e. Finding Words program).
- Community containment model for managing sex offenders in the community (CSOM/ATSA). This lowers the rate of recidivism, increases accountability and communication of professionals.
- Adapt Program – Victim Assistance Network. This lowers the incidence of reoccurrence, increases accountability.
- Offender internet monitoring tracks offender's internet behavior.
- Speedy investigation.
- Supportive prosecuting attorney.

##### **Victim services that are thorough, specialized and readily available provided by highly skilled professionals**

- Highly skilled advocates and therapists.

- Multidisciplinary teams (in some localities).
- Sexual Assault Response Teams (SART).
- Sexual Assault Nurse Examiner (SANE) programs geographically accessible, child specific SANE nurse and facility (better patient care and evidence collection).
- Availability of victim-witness advocate to support through investigation and trial by assisting with one-on-one support to each case, education on legal system, involvement in comprehensive support, housing, counseling, medical, transportation.
- Not letting victims feel lost in system by enhancing initial response: SART/Forensic Nurse Examiner (FNE)/shelter-advocate/special sexual violence investigator and the continuing process: crisis counseling, legal education, life/comprehensive care, education for law enforcement on response sensitivity and proper interviewing techniques, more training available, accessible for all service providers/law enforcement, access to outside trainings, experts, interviewing, sexual violence dynamics.
- Rapid response to therapeutic needs, not having to wait to see counselor, mental health counselors on staff at sexual assault crisis centers.
- Child advocacy centers.
- Hotlines.
- Comprehensive free counseling services; hospital response, post-assault crisis counseling, long-term therapeutic counseling.
- *Finding Words* program that trains professionals on how to conduct forensically sound interviews from a Multidisciplinary Team (MDT) approach (program provided through the Department of Criminal Justice Services - DCJS).
- Sex offender specific treatment for adults and juveniles to include polygraph, preferably by Certified Sex Offender Treatment Provider (CSOTP) and use of the Community Containment Model.
- Specialized treatment for victims, offenders, non-offending parents, and siblings. Specialized probation officers for adults and juveniles.
- SANE program.
- Having police and advocates respond jointly to meet victim at hospital in Alexandria.

### **Communication and cooperation among service providers**

- Service providers (advocates and therapists) who meet quarterly to share information and resources.
- Sexual assault council, multidisciplinary approach to service delivery from within the community, bimonthly meetings.
- Multidisciplinary case reviews: look at what went right and wrong and areas to improve upon.
- Child Advocacy Model – brings together professionals to improve investigations and prosecution.
- Multidisciplinary teams (in some localities).
- Child advocacy centers.

## **Barriers**

### **Schools are hesitant to provide information to students on sexual violence prevention**

- Abstinence based school programs are unable to address sexual assault and do true prevention work - lack of safe, supportive places.
- Stigma attached to sexual assault education makes it difficult to do prevention work in schools.
- Lack of comprehensive human sexuality education in schools, especially for people with developmental disabilities.

### **Community involvement is inadequate to meet victim needs**

- No active involvement of teachers.
- Faith-based communities sometimes refuse to acknowledge sexual violence.
- Disappearing suspects – non-cooperation and family/community to assist in arrest, tracking suspects down.
- Media's role in victim blaming; objectifying women, excusing violence against women.
- Lack of education in community about how to respond effectively to victims.

### **The prosecution process is inconsistent, time intensive and difficult for victims**

- Lack of prosecution.
- Lack of comprehensive and accurate reports by law enforcement.
- The defense's constant postponements are very discouraging to victim and hurts prosecution's case.
- No enforcement of cooperative agreements among law enforcement agencies.
- Poor victim notification regarding case postponements, status of case and release of perpetrator.
- No multi-disciplinary teams for investigation and prosecution.
- Overwhelming caseloads for commonwealth attorney's.
- Restricted access to forensic testing; large backlog; lack of capacity at state lab.
- Lengthy processing of victim compensation fund claims, especially for counseling needs.
- Lack of central database for suspects that crosses jurisdictions – more comprehensive.

### **Victims are sometimes met with suspicion by those in the criminal justice system when reporting sexual violence**

- Law enforcement "interrogates" victims.
- Law enforcement and prosecution do not believe victim if alcohol or drugs have been used by the victim.
- Inconsistencies of victim reports of the incident perceived as lying on by law enforcement.
- Law enforcement attitude and beliefs – reluctance to investigate sometimes.
- Victim-blaming attitude from law enforcement and commonwealth's attorney.

- Fear in community that police/system/other support/public reaction will not be supportive if assault is disclosed.
- Fear of retaliation and fear of victim blaming.
- “Good Victim” versus “Bad Victim” stereotypes that persist; hesitation or refusal to prosecute and/or believe the victim when alcohol or drugs are involved or used by victim in some jurisdictions.
- Victim blaming.
- Polygraphing victims to prove they are telling the truth.

**Some segments of the population have additional barriers to reporting sexual violence and seeking services**

- Lack of services and opportunities for immigrants.
- Cultural definitions of sexual violence are very different.
- Elderly, mentally ill and disabled are underserved – lack of trained providers and no reporting procedures for these populations.
- Immigrations status and fear of deportation discourages reporting.
- Non-legal immigration status – hard to find for follow-up if they are transient; fear of reporting to police; ineligible for services; cultural assumptions and stereotypes.
- Lack of cultural and language competency among service providers; lack of understanding concerning immigration issues.
- Enforcement of immigration law contributes to lack of reporting for sexual assault.
- Lack of resources to respond to women and men with a history of incest; working with male victims.
- More intense feeling of shame and blame among victims in some ethnic groups.

**Mandatory reporting laws contribute to the under-reporting of sexual violence of minors**

- No safe place for those under 18 years-of-age to report because of mandated reporting laws.
- Confidentiality and disclosure policies – for example, if student talks to guidance counselor about assault, counselor must report, this discourages teens from seeking help.

**Victim services are inconsistent across jurisdictions**

- Use and process of SANE exam is inconsistent across jurisdictions and not always a part of the investigation evidence.
- No local SANE program.
- Lack of standardization of care throughout state; state providing equalizing funding where large service gaps exist, for example, community service boards in Fairfax were great and in Winchester bankrupt only taking actively suicidal/psychotic patients.
- Not all jurisdictions have councils specifically for sexual assault.
- SART teams are not available in all jurisdictions.

- Location of school “good” versus “bad” part of town determines education on sexual violence.
- Too much separation of knowledge between specialties – for example, CPS, social service workers, on substance abuse and sexual assault.

**Current funding limits the provision of comprehensive services for victims of sexual violence**

Not enough funding for victim advocates.

Inadequate pay to retain qualified and professional staff, including commonwealth attorney’s, forensics, and rape crisis centers.

- Lack of financial resources for victims, especially if dependent on attacker.

Need for funding for child advocacy centers, *Finding Words* training, SANE program, juvenile sex offender services, and victim services/treatment.

- Free, accessible and available long-term counseling for victims.
- Not enough staff in crisis centers.

**Some service providers do not receive training in how to effectively respond to victims of sexual violence**

- Lack of training for advocates, law enforcement, prosecutors, judges, mental health, social workers, etc.
- Lack of resource’s for training law enforcement and commonwealth attorneys for interviewing victims, such as *Finding Words* program.
- Uneducated prosecuting attorneys and no leverage to encourage education.

## **Recommendations**

### **Increase information for the public regarding issues surrounding sexual violence**

- Heavy advertising for victims, to know they are not alone (PSA's) like the Virginia Department of Social Services – [www.itscloserthanyouthink.org](http://www.itscloserthanyouthink.org).
- Ask advocates and therapists for input in writing public service announcements.
- Educate people on the intersection of domestic violence and sexual assault and stalking.
- More funding for educational and prevention programs targeted at kids.

### **Increase sexual violence education and prevention programs in public schools**

- Design programs in schools around healthy relationships and teen dating violence.
- Educate all students but specifically work with at risk youth and those involved in substance abuse recovery and teen pregnancy.
- Increase access to schools for prevention and access to information in schools (brochures, etc.)
- Statewide legislation for inclusion of sexual abuse education programs in schools.

### **Increase enforcement of existing laws and penalties for perpetrators**

- Civil seizures (cars, etc) law to include sexual predators/travel/internet.
- Increase in consequences for mandated reporters that are not reporting incidents of known sexual abuse.
- Research the efficacy of the sex offender registry.
- Statewide implementation of the Community Containment Model.
- More consistent prosecution of adult and juvenile offenders.
- Statewide specialized sexual violence juvenile and adult probation officers.

### **Reduce the strain of the prosecution process on the victim**

- Increase the capacity to handle evidence, 2-3 month turnaround for all crimes, from peeping toms to violent offenders.
- Timely notification (email, phone, in person) to victim, advocates, therapist, (i.e. "the team") of court processes.
- Designated "point person" for victim to call.
- Reduce forensic lab processing time to 2-3 month turnaround for all cases.

### **Develop standards and systems that establish consistent responses to victims of sexual assault across jurisdictions**

- Consistent investigation practices across all jurisdictions.
- Uniform interviewing protocol (forensics).
- No polygraphing of victims
- Transparency of reporting mechanisms for law enforcement and rape crisis center services such as websites, and newsletters. Letting people know the data is there.
- SANE exam to be part of investigation.

- Develop plan to deal with SANE exams without law enforcement cooperation and report so Virginia is in compliance with federal law – Violence Against Women Act.
- Formalize and standardize role of victim advocates (both rape crisis center and victim witness staff) in support of clients. Allow greater access; provide increased staff, more one on one time.
- Funding for sexual violence prosecutors – specialized.
- Create statewide groups of special sexual violence investigators that could respond to rural communities without those resources, using retired investigators as resources.
- Follow up to make sure survivors are not paying for their own Physical Evidence Recovery Kit (PERK) and exam.
- Review state policies that impede use of best practices.
- Statewide legislation for child advocacy centers, members of MDT should have mandatory participation.

**Develop strategies and programs designed to address the unique needs of specific segments of the population**

- Provide more resources for offenders with mental retardation.
- Need for assessment center for juvenile offenders who have been charged with sexual offenses and cannot return home.
- Funding for resources for underserved populations such as, college students, disabled, mentally ill and elderly.
- More funding for juvenile residential programs so kids do not have to go into foster care.
- No negative legal recourse for victims of sexual violence – no immigration customs enforcement involvement.
- Provide services within diverse communities that may not be willing to access mainstream services.

**Establish multi-disciplinary teams to respond to incidences of sexual assault**

- Mandatory attendance in SART meetings from Governor's office.
- Multidisciplinary teams (law enforcement, prosecution, advocates, therapists, medical, various cultural leaders, faith-based, child protective services, SANE).
- Funding for community councils that could coordinate sexual violence services and fill-in funding/service gaps.
- More funding: make this issue a priority specifically for training, developing resources, SART teams, services for male perpetrators and victims, SANE geographically accessible, mental health counselors on staff at crisis center.
- State funded training to begin SARTs.
- Create community member boards to allow resident input and increase communities ability to influence sexual violence services and response in the area.

**Increase sexual assault training for professionals throughout the response system**

- Cross-agency counselors/advocates trained in response to victims in legal system and funding for this training.
- Need for cultural/language sensitivity training for all professionals, including police.
- Train prosecutors and judges on non-stranger sexual assault.
- More training for law enforcement.

**Establish statewide training requirements**

- Mandatory education for law enforcement on non-stranger sexual assaults.
- Mandatory specialized training for judges.
- Establish first responder training requirements for recertification for sexual violence, similar to the National Incident Management System established by the Federal Emergency Management Agency.
- State-endorsed training recommendations for judges and other criminal justice professionals.
- Juvenile probation/court should require parents to attend sexual abuse education program.
- Mandatory training on responses to sexual assault for law enforcement.

## **Governor Kaine's Commission on Sexual Violence**

### **Southwest Virginia Input Session Summary**

#### **Best Practices**

##### **Prevention programs in schools and colleges**

- Collaborating with universities and the community to encourage volunteer involvement.
- Rape prevention education programs as part of school curriculum (ex-relate).
- Use of tested bullying curriculums for younger children in school.
- Continued education through presentations in school systems, K-10<sup>th</sup> grades.
- Early education – continuous (preschool, primary, middle and high school).
- Campus education – plays, self-defense, posters, seminars.

##### **Public awareness of sexual violence and community involvement in prevention and treatment**

- Parent education continuum.
- Information on sexual violence available at doctor offices, college health services, clinics, hospitals, family planning clinics.
- Outreach education with clubs, Parent Teacher Association (PTA).
- Overall community organizations and allied professionals.
- Community education program.
- Community outreach and education, awareness events, media (Public Service Agreements (PSAs) and newspapers).
- Teaching children and adults Rape Aggression Defense (RAD).
- Public awareness brochures.
- Media coverage – news coverage, newspapers, television campaigns, commercials.
- Increase in the amount of articles, research and publications.
- Increased awareness of non-stereotyped survivor groups.

##### **Prevention programs available to the community**

- Primary prevention programs like *Domestic Violence Prevention Enhancement and Leadership Through Alliances* (DELTA).
- Formalized family/sexual violence programs.
- Prevention programs e.g. *Men Against Rape*.
- *Hugs and Kisses* program.
- Virginia Department of Health (VDH) funded prevention programs.
- *Take Back The Night* programs.

##### **Effective prosecution of offenders and extensive post-conviction monitoring**

- Global Positioning Service (GPS) offender monitoring – for police and corrections/probation/parole.

- Increased forensic capabilities.
- Perpetrator treatment programs.
- Websites with registered sex offenders.
- Availability of grant funded positions.
- Criminal history/records.
- Registered sex offenders/public access.
- Domestic violence courts.
- Law enforcement – resource sheets to start immediate referral process.
- Up-to-date application of laws that affect victims.
- Availability of forensic medical evaluation services.
- Creation of Governor's Commission, legislative awareness.
- Violence Against Women Act.
- Sex offender registry.
- Law enforcement passionate with child abuse cases.
- Blind reporting.

#### **Availability of trained forensic nurses**

- Forensic nurses.
- Increase in forensic nursing program and communication with these programs – on call companions available for sexual assault victims.
- Certified forensic nurses.
- Forensic Nurse Examiner (FNE).
- Use of trained forensic interviewers.
- Forensic nurse as a tool/resource.
- Sexual Assault Nurse Examiner (SANE) communities – trained, professional, consistent nurses.
- SANE programs.
- Access to forensic nurses.

#### **Specialized centers for victims of sexual violence**

- 211 as a resource.
- 2-1-1 Connection – 1 phone call for available resources.
- Women's Resource Centers.
- Child Advocacy Center.
- Virginia Tech Women's Center.
- Danville Domestic Violence Shelter (houses men, women and children), partnership with local hospital and shelter.
- Children's Advocacy Center.
- Teen Health Centers.
- Hotlines, crisis centers, free services, group counseling, Art of Survival.
- Child Advocacy Center model – interview room, trained, professional interviewer.
- Community resources – hotlines, domestic violence, Substance Abuse and Rehabilitation Program (SARPs).
- Community Service Boards – Sliding Scale Fee.

**Victim advocacy and support available for victims of sexual violence**

- Support groups for adult survivors of childhood sexual abuse to address multi-generational abuse.
- Self-esteem support groups.
- Developing and providing specific support groups for victims.
- Individual and group counseling services for adults and children.
- Local free counseling for victims/families.
- Companion Program.
- Council on Aging works to connect older citizens who are victims to appropriate services.
- Rockbridge CARES.
- Increase in victims' groups and advocacy groups.
- Rape-Crisis hotlines.
- Victim-Witness programs.
- Specialized services for sexual assault 24/7.
- Quick response from police.
- Hospital accompaniment by advocates for presenting victims.

**Multi-disciplinary teams trained for response to sexual assault**

- Multi-disciplinary team approach for child sexual abuse (law enforcement, Department of Social Services (DSS), prosecution, medical, mental health, victim advocacy, school).
- MDT (Multi-Disciplinary Team [children]).
- Multi-disciplinary teams.
- Sexual Assault Response Teams (SARTS) – some cover child abuse, domestic violence, sexual violence
- SARTS - Some cover case specifics
- SARTS - Some trouble shoot the process and/or communication
- SART (Sexual Assault Response Team [adults])
- SARP (Sexual Assault Response Program)
- Victim Witness Program
- SART creation/implementation
- Teamwork – forensic nurses, interdisciplinary teams.

**Communication and cooperation among service providers**

- Coordination of services.
- Monthly coordinating councils.
- Awareness of continuum of services.
- One facility encompasses all disciplines.
- Inter-agency cooperation.
- Interagency collaboration, i.e. new data exchange methods.
- Collaboration of allied professionals.
- Multi-disciplinary coordinating councils in individual localities.
- Monthly collaborative meetings per region (with cross training), involving the criminal justice system and allied professionals.

- Coordinating councils.
- Existence of family violence coordinating council who meets regularly.
- Local tasks forces (Allegheny Anti-Violence Coordination Convention, Rockbridge CARES).
- Interagency communication – SART. Including: Law enforcement, shelter, DSS, victim-witness, SANE nurses, local universities, Court Appointed Special Advocates (CASA) courts, Commonwealths Attorney.

**Availability of specialized training for professionals, staff, and volunteers**

- Emphasis on training/investigative capabilities for assigned investigators.
- Training availability.
- Training and awareness videos.
- Training provided to professionals in reference to issues related to child sexual abuse.
- Trained staff and volunteers.
- Well-trained professionals.

## **Barriers**

### **Prevention programs are not available in all communities**

- No sufficient information or awareness information on crime prevention.
- Lack of ribbon campaigns.
- Limited resources (education/awareness).
- Very little prevention/education to youth – needs to be mandated.
- Lack of understanding and investment in “primary” prevention.
- Censoring of words and concepts in school systems that inhibit prevention.
- Prevention efforts seem to target safety strategies for victims, rather than prevention of the crimes.
- Do not know how to prevent sexual assault.
- Getting information to people who need it the most.
- Insufficient education.
- Difficulty in getting into school systems.
- Public unclear about what sexual assault programs do.
- People choose to be uneducated concerning these issues because it does not fit into their belief system.
- Not enough information and lack of knowledge known by public about sexual violence.
- Public awareness – information needs to be more accessible for victims from victim witness/rape crisis.
- Low public awareness of severity.
- Cultural norms.
- Ineffective education.
- Lack of education on sexual assault/power and control.
- Colleges/universities are closed systems.
- Language barriers exist.
- Lack of parental awareness/community.

### **Prosecution process is inconsistent and discouraging to victims**

- Inconsistencies within magistrate and juveniles intake systems.
- Inadequate resources – i.e. closed circuit testimony, etc.
- Loopholes within Judicial System.
- Crime Scene Investigation (CSI) mentality.
- Court system re-victimization.
- Inadequate victim notification.
- Inadequate laws and court procedures such as waiting for PERK results before trial.
- Crime lab – delay of processing evidence for DNA.
- High case loads.
- Lack of response to sibling abuse and/or abuse by juvenile offenders.
- Lack of recognition of importance of close-circuit testimony for sexual assault/abuse victims.

- Court system may not use available technology.
- Definition of sex offenders/offences.
- “Winnable” cases are most important.
- Lack of reimbursement (improve understanding of reimbursement process).
- Improve reimbursement (programs in hospitals, SANE, FNEs).
- Lack of consistency of response from law enforcement /court/judges.
- Reluctance to investigate without physical evidence.
- Reluctance to investigate if alcohol/drugs are involved (by victim)?
- Bias – Amongst professionals.
- Multiple interviews of victim.
- Victim unwillingness to carry through on cases.
- Victim-blaming.

**Victims of sexual violence are often looked upon with suspicion by the community and are reluctant to report abuse**

- People are afraid to get services because of stigma or legal consequences.
- A rigid hierarchy that includes gender and class biases.
- Impact of stereotyping victims.
- Devaluing victims as a class.
- Culture/media acceptance/promotion of violence and sexual activity
- Stigma – willingness not to report or seek treatment
- Attitude that sexual assault victim is lying.
- Victim not wanting to press charges because of attitude of others.
- Stigma/shame attached to reporting.
- Law enforcement/community perception of sexual violence.
- Concerns with retribution and victim protection.
- Under reporting.
- Powerless child victims.
- Victims’ fear of destroying credibility of family.
- Victim use of drugs facilitated sexual assault.
- Fear of not having confidentiality (rumors, gossip).
- Fear of public awareness/ridicule.
- Need to distance self from victim/denial that sexual assault happens.
- Victim’s cooperation in legal procedures.
- Negative press coverage.
- Attitudes centered on victims/stereotyping.
- Victim blaming.
- Lack of focus on changing societal norms re: view of sexual assault, stereotypes of victims, victim-blaming, putting the victim on trial.
- Lack of public awareness due to stigma.

**Comprehensive services for victims of sexual violence is limited**

- Isolation – rural.
- Lack of treatment programs for perpetrators with history of victimization; no effort to address re-victimization.
- Mental health treatment services waiting lists.

- Geography (unable to access services).
- Lack of therapy groups.
- Lack of sexual violence shelters: emotional support, education re: process, provide assistance after court, work with victims toward long-term recovery/Victim-witness more legally oriented, link to Crime Victim Compensation Fund (CVCF), “clerical support for Commonwealth's Attorney”, supporting prosecution by regulating access to CVCF.
- Statewide misunderstanding of the differences between the roles of victim/witness vs. advocates.
- Lack of funds for victims who do not want to prosecute: Sexually Transmitted Disease (STD) prophylaxis/pregnancy prophylaxis.
- Lack of treatment/provider resources.
- Limits to 911 system – notification vs. response, ability to locate victim.
- Lack of access to transportation.
- Lack of intervention for victims before they become perpetrators of all violence.
- Reimbursement by 3<sup>rd</sup> party payers for medical evaluations of victims is extremely limited and discourages physicians from performing exams.
- Lack of knowledge re: monetary resources – victims at times do not seek medical treatment when needed.
- State labs are under-staffed and under-funded.
- Meeting hierarchy of needs.

**Inadequate number of service providers to meet victims' needs**

- Inability to utilize forensic nurses to the fullest extent possible.
- Not enough staff/coverage/volunteers for extensive areas served.
- Pay is low – hard to attract professionals.
- Not enough funding for SANE/SART/DELTA/Rape Prevention and Education (RPE) development because of conflicting priorities and lack of education.
- Lack of forensic nurses programs.
- Insufficient number of staff to serve sexual assault population.

**Inadequate resources for specific segments of the population**

- Not many services specifically for children.
- Lack of involvement of males; lack of resources for male victims; education and prevention work with males in general.
- Lack of funds for costly prophylactic medications (HIV medication).
- Mental health issues can prevent victims from self-advocacy (victims with dementia, Alzheimer's, etc.).

**Inadequate communication and cooperation among service providers**

- Lack of communication and collaboration with allied professionals.
- Need for uniform protocol in responding.
- Ineffective inter-agency communication.
- DSS needs to be involved in allied professional response to treatment/intervention.
- Other agencies (commonwealth's attorneys/law enforcement) need to respect

- victim service agencies.
- Utilize sexual assault centers' services respectfully.

**Some service providers do not receive adequate training in responding to sexual violence**

- Lack of trained professionals on sexual violence, i.e. being charged with false reporting/judges.
- The legal professionals lack knowledge and education on sexual violence.
- Knowledge deficit in judicial system – judges and attorneys need to be provided additional trainings to properly understand sexual violence.
- Health care providers lack of education and ability for identifying victims of violence.
- Lack of funds for medical personnel training for training and continued education.
- Inadequate training.
- Lack of education among professionals in legal system.
- Lack of training for law-enforcement (the ones who need it most do not come).
- Access to funding for training for law enforcement is limited.

**Inadequate state commitment to addressing sexual assault**

- Patriarchal attitudes of general assembly which carries over to general public.
- Denial by our legislatures that sexual violence on all levels happens everywhere and includes children.
- Not enough money for sexual violence programs – it's not a priority for the general assembly/budgeting professionals.
- General assembly not allocated money for services for sexual assault.
- No state funding for coordinated community efforts (though it is best practices) because of conflicting priorities.

**Other**

- Recidivism (convicted predators) – monitoring and rehabilitation.
- Inadequate internet safety and monitoring.

## **Recommendations**

### **Provide information to all students on sexual violence prevention**

- Formulated or mandated educational/crime prevention programs.
- Mandated programs for all educational levels in all schools (including Charter Schools).
- Increased emphasis on funding for primary prevention in elementary, middle and high schools, such as Department of Health funded programs e.g. *Rape Prevention and Education* (RPE).
- Programs like *Men Against Rape*, beginning in middle schools or earlier (part of RPE).
- Educate all disciplines, grade school through college and educate minority groups for reporting.
- Require violence prevention education in schools.
- Reviewing the “family life” curriculum to see if it includes sexual violence awareness in elementary and middle school.
- Ensure family life education is part of social curriculum as an avenue for sexual assault education.
- Education in schools around sexual assault issues as part of the Standards of Learning (SOL).
- Education on internet safety in schools/community.
- Prevention education for young children (mandatory).
- Mandated child education.
- Need violence prevention as a priority.
- Education – more to the community.
- Student Assistant programs in schools.
- Communication about sexual violence with community members – expand training/presentations.

### **Increase public awareness of issues surrounding sexual assault**

- Media campaigns that rely on community-wide evaluation of best practices.
- Universal public service campaign against violence.
- Create national information media campaign about sexual violence.
- Media/radio required to run sexual assault specific public service ads.
- Increase public awareness efforts for service providers.
- Education: High profile/visible (television, bill boards, buses, grocery stores).
- Increased state money for sexual assault prevention work.
- Mini-grants for Public Awareness Campaigns and education.

### **Increase penalties for perpetrators and increase enforcement of existing laws**

- Enforce current laws by documenting no contact with children and register as a sex offender.
- Mandatory involvement in treatment programs, even for 1<sup>st</sup> offenders.
- Updating sex offender registry.
- Legislation: extensive background checks, harsher sentencing, earlier rehab, mandated pre-18 victim therapy, increased restitution to victim.

- Differentiate between sexual crimes.
- SVU (Special Victims Unit) teams.
- Mandatory punishments/consistent.

**Develop standards and systems that establish consistent responses to victims of sexual assault**

- State mandated protocol (procedures for prosecution and investigation/ magistrates/ intake.
- Require localities to identify gaps in sexual violence prevention.
- Consolidation of sexual assault/domestic violence providers under umbrella for more consistency and better evaluative tools.
- Method of review by the Attorney General's office on controversial cases.
- Universal domestic violence court model.
- Universal perpetrator treatment and follow-up.
- Mandated forensic nurses at all hospitals.
- Consistent practice for victim witness staff to notify sexual assault centers.
- Standard of care for victims (hospitals).
- State level-required sexual assault written policy for law enforcement.
- Consistent practices among law enforcement, judges, prosecutors (policies, directive orders).
- Legislation for forensic nurses on staff at all hospitals or available to all times through health departments.
- DSS address/treat child, disabilities, elderly and sexual assault cases the same.
- Dedicated areas for victims for confidentiality (hospitals).
- Stronger language to support MDT meetings and Child Advocacy Centers (CAC) through to the code of Virginia.
- Mandated joint investigation.
- Expand use of closed-circuit testimony for child abuse victims.
- Allow rights for victims equal to what the defender has.
- Make victims of violence a priority with legislators and law makers.

**Increase funding for comprehensive services for victims of sexual assault**

- Identify funding sources for programs such as labs, education, forensic nurses.
- Take into consideration the geographical and population stats when cutting funds – rural areas pay the price!!! Look at ratios of service provision, not numbers.
- Easier access to funds for victims i.e. treatment, medical reimbursement.
- Support on-going operation/expansion of child advocacy centers through continued state funding.
- Allocate funds for adequate treatment facilities.
- Raise funding cap for sexual assault funds.
- Additional funding needed for sexual assault program staff (advocates, educators, etc.)
- Criminals should be mandated to compensate financially to sexual assault programs on a local level.
- Provide incentive for forensic nurses from medical professionals to buffer turn-

over rates.

- Fund comprehensive sexual assault crisis services in every jurisdiction.
- Provide a Center for women/victims that would provide holistic services; would cover legal, medical, etc. and could be utilized for emergency situations, i.e. Radford's center.
- Increased emphasis on funding for comprehensive SANE programs, including community collaboration, hospital accompaniment, court advocacy, long-term care for primary and secondary victims.
- DELTA funding activities focus for community collaboration around domestic violence and sexual assault.
- For SOSA (Adult Survivors of Childhood Sexual Abuse) funding to improve support groups and long-term recovery activities – important because sexual assault is often multi-generational.
- Increase forensic programs in rural areas.
- More forensic nurses hired and mandated Physical Evidence Recovery Kit (PERK) availability and forensic nurse availability in various localities.
- Child Advocacy Centers developed for all areas.
- Access to Forensic Nurse Examiners (FNE) in all areas.
- Treatment centers in all localities.
- Provide "One Stop Shops".
- Victim resources for follow-up.

#### **Increase collaboration across agencies and organizations**

- Work towards collaboration between private vs. public (govt. sector) for example: hospital buy-in, participation.
- Adult/child coordinating councils in all areas.
- Formation of teams in every locality - Multi-Disciplinary Teams (MDT) and SART.
- Interdisciplinary teams.
- Create task force to prevent internet crimes.

#### **Establish and require training for professionals throughout the response system related to victims of sexual violence.**

- Specialized training for professional networks.
- Mandatory sexual violence education/training for all police officers at police academy and incorporate sexual assault crisis centers.
- Mandatory sexual violence education for legal professionals, teachers, social workers, legislators.
- Better education and training for first responders.
- Training of prosecutors, judges, law enforcement on victim sensitivity interaction – solution: projects like Grants to Encourage Arrest Policies (GEAP).
- Training for law enforcement personnel in working with assault victims who also have mental health illness issues (Virginia Institute for Social Services Training Activities (VISSTA) training courses offers this).
- Support healthcare provider training in sexual abuse evaluation: options – 1) funding to develop curricula in physician residency programs 2) 1-2 day

regional continuing medical education training programs for practicing physicians.

- Strengthen prosecutors' knowledge of trial strategies in case of sexual assault through curricula development and ongoing mandatory training.
- Mandatory training – agencies and organizations involved in working with victims of violence.
- Pilot programs (multi-disciplinary) to educate legal community, re: sexual assault and to eliminate duplication of services (ex: GEAP- related funding and activities) and to encourage best practices for judges, commonwealth's attorney, magistrates, law enforcement and victim/witness.
- Mandatory sexual assault training for all law enforcement and specialized training for investigators.
- Statewide uniform training for professionals.
- Mandatory uniform training for law enforcement by Department for Criminal Justice Services (DCJS).
- Mandatory training for all persons in the Legislative and Judicial community.

## **Governor Kaine's Commission on Sexual Violence**

### **Central Virginia Input Session Summary**

#### **Best Practices**

##### **Expand sexual violence education in public schools and colleges**

- Consent campaign at University of Virginia, educate at effective consent.
- Peer theatre – students act out scenes of sexual violence and engage the audience.
- Single-sex education.
- Institutional backing for prevention education – engaging Department of Education.
- Prevention: K-12 education – Expansion of pre-K education (daycare).
- Prevention: Mandatory research based education programs for college students.
- Assessment of education programs.
- Programs for elementary, middle, and high school students.
- Grants to increase education.
- Teen task forces.
- Increase in public education and programs Richmond Organization for Sexual Minority Youth (ROSMY) to address same sex assault.
- Education occurring on signs and symptoms of violence assault.
- Family life education – awareness and risk reduction.

##### **Community-based prevention and public awareness programs**

- Buddy system – encourage women to use a buddy when going out.
- One in Four – men as educators to other men.
- Community outreach – Theatre IV, “Hugs and Kisses”.
- Alcohol education/consent.
- Empathy focused programs.
- Identifying stakeholders in a community and experts in the field.
- Programs that focus on conditions and attitudes – working to address sexual violence before it happens.
- Community outreach awareness education from domestic violence/sexual assault programs works to change attitudes, collaboration between nurse and programs.
- Ability to educate/inform advocate for victims/general public.
- Ability to educate across cultural barriers/military.
- Local community support – links with other professionals/agency (using existing agency/community to start education. Go to city counsel; go to Better Business Bureau, churches, and women’s groups).
- Community Peers.
- Ability to educate on gender issues.

- Primary prevention programs thru sexual assault crisis centers – preventing perpetration, changing social norms such as gender rules, healthy sexuality, media images, respect of boundaries, etc.
- “Getting to Outcomes” – Center for Disease Control – Provide communities with a step-by-step process for making a prevention plan that fits their needs.
- Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA) program – community-based development prevention program thru CDC; target audience is any age; main idea is healthy relationships.
- “Men Can Stop Rape Program”.
- Care for kids out of Vermont – pre-school program focuses on healthy sexuality.
- Safe Dates out of North Carolina focuses on early adolescent relationships.
- Prevention: Counties/districts have local domestic violence task force – outreach education source of information contact – sexual assault centers/program.

#### **State-supported public awareness campaigns**

- Isn’t She Too Young – Virginia Department of Health (VDH) awareness campaign focuses on young males. Peer-to-peer campaign. Bystander action.
- White ribbon campaign – sexual violence awareness for males.
- Teal ribbon campaign – sexual violence awareness month.
- Stop It Now campaign – hotline for information on preventing sexual assault.

#### **Effective investigation and prosecution of offenders by trained personnel**

- Availability of closed circuit equipment/trained law enforcement.
- Coordinated law enforcement response (offices/prosecutors).
- “Kids Court” – victim witness, courtroom tours.
- Targeted prosecution – early contact with victim.
- Shared information from jurisdictions.
- Medical records.
- Forensic Nurse Examiner (FNE) records.
- Pro Bono legal services.
- Prosecution: Specialized training/consistent tasking of Commonwealth Attorney’s (CA); vertical prosecution.
- CA’s assigned to cases from the beginning.
- Improvement in police attitudes toward sexual assault (less victim blaming).
- Legislative changes have been helpful (dropping marital assault).
- The Debbie Smith Law.
- Dedicated police officer, prosecutor for sexual assault; special groups.
- Definitions of abuse/neglect assault – verbal, sexual, physical.
- Court Appointed Special Advocate (CASA) program.
- Victim/witness coordinator.
- Victim/witness coordinator – coordinates between law enforcement and prosecutor on behalf of victim; coordinate with FNE teams.
- Prosecution of offenders – designated detective unit for domestic violence and sexual assault have more training and are more sensitive to victims – helps with evidence collection.

### **Availability of forensic nurse examiners**

- Forensic nurses – examine victim regardless of whether or not they are reporting to law enforcement – immediate response – no waiting by victim for exam.
- SANE programs – Where available are working well (front lines for evidence collection and victim resources) these are trained and experienced resident nurse (RN)'s.
- Make all hospitals adult/child – SANE, Physical Evidence Recovery Kit (PERK).
- Forensic/advocate at hospital.
- Forensic nurses.
- SANE nurses.
- SANE program.
- FNE (Forensic nurse examiner).
- Nurse and advocate on site within one hour; safety plan started, evidence collected, officer leaves with complete evidence; advocate follow-up plan.

### **Victim support and advocacy**

- Victim advocacy (YMCA)/Victim witness including shelters, counselors, hotline, student witness programs, peer counseling.
- Transportation by police to forensic exam.
- Victim witness helps with financial needs.
- Victim compensation fund.

### **Specialized centers and treatment programs**

- Internet resource based programs.
- Treatment: Criminal Injuries Compensation Fund (CICF); increased number of private practice counselors specializing in sexual assault recovery.
- Hotlines – state, local, national – information, referrals, advocacy, listening hear, appointments with counselors.
- Sexual assault crisis centers – supportive services – legal advocacy, court advocacy, support groups, hospital accompaniment, counseling, shelter crisis intervention, suicide prevention.
- Camp Mabon (retreat for sexual assault survivors) that provides a positive experience and empowerment for survivors.
- “Safe Place” – police notified immediately i.e. shelters for domestic violence victims; crisis counseling.
- Red card resources – referrals.
- Crisis programs.
- Availability of grant money and the ability for hospitals and schools to receive it.
- Victims of Crime Act (VOCA) grant.
- Hospital advocate at the Medical College of Virginia (MCV).

### **Programs for children**

- “Finding Words” (child abuse) – Forensic Interviewing Protocol and Child Advocacy Centers.

- Child advocacy center where children can report – Charlottesville.
- Child Assault Prevention Program (CAPP) – pre-thru high school.
- Intervention programs for children who witness violence, for example, "React" program in Colonial Heights.
- Removing perpetrator, not child.

### **Cooperation and coordination among service providers**

- Coordinated community response – first response, treatment offenders, counseling victims.
- Identifying causes, realistic solutions, resources available to achieve solutions, holding regular meetings between stakeholders and service providers to encourage open communication and maximum resources.
- Intervention: Collaboration between the police department and Child Protective Services (CPS) in investigation first, additional collaboration with Commonwealth Attorney's and Victim Witness Assistance Program (V/WAP) if case is prosecuted; recognizing family and witnesses as victims and providing services.
- Coordinated community response Sexual Assault Response Team (SART) – bringing stakeholders to the table and looking at issue holistically.
- When local sexual violence agencies collaborate, they work well together, effectively.
- SART teams work, because of collaboration of agencies and resources help victims.
- In some areas agencies (Department of Social Services, healthy families, local sexual violence) are communicating well thru referrals joint trainings DSS giving out local program information.
- Community response – Child Abuse Response Team (CART) meetings, response team including sexual assault and domestic violence, Department of Social Services and Crisis programs and Safe Place law enforcement, Gatty – meet to review cases.

### **Multidisciplinary teams are working to provide timely and thorough first response to victims of sexual violence**

- Multidisciplinary Team – coordinated community response – Charlottesville.
- SART/Coordinated Community Response (CCR).
- Second responders – unit of DSS social workers that work with police department at night responding to any human service call and respond to emergency room (ER) when there are no other advocates (Richmond city service but they respond to non-city residents at Richmond hospitals to make referrals).
- Second responders – social workers on site with police in sexual assault and domestic violence cases.
- FNE/SART team.
- Immediate, consistent response by local rape crisis center.
- V/Witness involvement early to alert victim to resources, etc.
- ER (MCV) sexual assault advocate on site organized and follow up case.

- Victim/witness programs – understanding court process.
- Crisis response program.
- Primary crisis support relationships advocate – coordinated.

**Some training is currently offered to service providers**

- Training on definitions – response, counseling.
- Establishing empathy.
- Ability to screen and educate for first line providers including Emergency Medical Services (EMS).

**Other**

- Ability to use research to guide practices.
- Ability to confront denial – hospital.
- Screen healthcare or providers background checks.
- Ability to work with prevention perpetrators.
- Evaluation/treatment programs for offenders, particularly juvenile offenders; inclusion of family members.
- This commission.

## **Barriers**

### **Some schools are hesitant to provide information to students on sexual violence prevention**

- Education – anyone: schools, hospitals, community groups, churches.
- Schools no longer involved in prevention and training on signals of abuse and what to do because of priorities like standards of learning (SOL).
- School systems: Limitations/willingness to discuss sexual violence – prevention education, recognizing and responding to sexual violence in their school system, fear of the unknown, parents.
- School system – tough to get in/very restrictive on what you can say.
- Convincing colleges/universities to do more than one hour of education!
- Lack of institutional knowledge as to what they are required to do in terms of protecting students, workers, etc.
- Age-appropriate messages.
- Need for elementary school programs like Drug Abuse Resistance Education (DARE).
- Prevention: alcohol's role not heard/understood by adolescents.

### **The public is not receiving adequate information on sexual violence**

- Lack of education about nature of child development and impact of sexual abuse and domestic violence. Child changes story so considered lying.
- To reducing sexual violence: Lack of education among family and professionals in identifying offenses and offenders, economics/financial dependence of victims on offenders.
- Lack of education on issues – lack of sensitivity.
- Public awareness, judgmental attitudes victim-blaming.
- Rape vs. consensual sex.
- Desire to separate “us” and “them” when it is an issue that touches everyone.

### **Process of prosecution is inconsistent and difficult for victims**

- People do not want to disclose repeatedly (police, hospital personnel).
- Sometimes reporting and going through systems is not the best for victims.
- Legal System increases pain for victims – poor understanding of child development, expediency of processing cases (delays), basic factors that court would be guided by, need guidelines to allow victims to get faster services and appropriate services.
- Lack of speedy trial.
- Transportation – resources located in different agencies and buildings.
- Victim not wanting invasive exam and refusing assistance.
- Insufficient victim support.
- Public nature of a trial is too much scrutiny.
- Difficulty in prosecution.
- Children are being missed.
- No documentation of allegation maintained by Commonwealth Attorney's.
- PERK – Physical Evidence Recovery Kit – take too long to obtain results.

- Legal system is not well suited to address sexual violence
- Ineffective prosecution – training, time, experience, lack of specialized prosecutors in this area.
- Reluctance of prosecutors to take on cases where drugs/alcohol are involved/acquaintance rape situations.
- Crime Scene Investigation (CSI) effect – too many people thinking “no DNA/no crime”.
- Commonwealth attorney only take winner cases.
- Judicial system need more timely response in sexual assault cases – limit continuances delaying tactics by defense to undermine will of reporting person court docket scheduling.
- Lack of dedicated staff in victim/ witness/advocacy/law enforcement/prosecution – number of people.
- Delay in PERK processing.

### **Victim-blaming and victims treated with suspicion**

- Victim blaming – not recognizing who is responsible. Law enforcement doesn't treat as seriously as other violent crimes.
- Guilt/shame of victims.
- Polygraphing victims inappropriately – require for investigation to occur or continue.
- Delayed reporting by victim or parent (stigma, no one to talk to, self-blame).
- Public attitudes about women' sexuality – putting the victim on trial – questioning of the victim's credibility.
- Responding effectively to victims: Criminal justice process-reporting, investigation, prosecution, media.
- Victim blaming (by society at large, service providers, by family/friends who should be supportive).
- Victim blaming within agencies (law enforcement, social services, hospitals – attitudes vary).
- Substance use/abuse decreases knowledge of what occurred creates guilt/fear to report due to concerns at prosecution.
- Consequences for reporting – don't want statistics known (not in my house, neighborhood, school).

### **Community attitudes toward sexual violence**

- Social attitude re: sexual assault due to lack of education, “she's going to recant things”.
- Live in a culture of violence: Turn off television, social aspect of children/adults, acceptance of violence, diminished sense of responsibility.
- Social messages that “entitle” males to force sexual activity.
- Discomfort in society with sexuality – can't use correct words, discuss sexuality in schools or other youth settings.
- Community awareness and acceptance of the occurrence of abuse – public, family, neighbors, police.
- Society's fear or inability to openly discuss sexuality.

- Sexuality as a game to be won or lost.
- Media – public awareness, understanding and identifying sexual violence – not always violent.
- People view sexual assault as a problem of the individual, not a societal problem.
- Inappropriate reporting by media.
- Denial of sexual assault by communities (i.e. don't recognize that most sexual assault is perpetrated by friends, family members).
- Some victims are more likely to be discounted based on race, language, disability, class, age, sexual orientation, etc.
- Family silence.

**Stigma of sexual violence and under-reporting occurrences of sexual violence**

- Stigma – Denial: Need to have people recognize the complexity and depth and impact of the problem.
- Persistent rape myths.
- Stigma of foster care.
- Existing discussion only focuses on the negatives.
- Attacking stigma of abuse – getting to person who are victim who will not come forward (barriers of family dynamics), fear to disclose because of consequences on professional if disclose who become less credible.
- Barriers to reporting: self-blaming, lack of awareness and prevalence, what constitutes rape, lack of faith in justice system, financial consequences, time lag to completion.
- Refusal to admit the sexual violence that occurs in prisons – particularly if perpetration is an employee of the system.

**Some segments of the population have additional barriers to reporting sexual violence and seeking services**

- Language barriers.
- Language/cultural.
- Victim with mental health issues or physical disability – easy target for victimization, challenges accessing services.
- Adult homes – patients targets for sexual violence.

**Limited availability of programs/treatment in rural areas**

- Lack of support, low funding – particularly in rural areas (child advocacy centers needed!). Not enough man power. Not using persons of knowledge adequately.
- Information about sexual assault and alcohol in rural areas and in various age groups.
- Shelters – not in rural areas, not enough, denied services due to age of children, pets, and drug problems.
- Rural areas lack resources of urban localities.

**Insufficient centers, resources, and programs to meet victims' needs**

- Staff – ex: SANE nurses not at a hospital 24/7, need more advocates, etc.
- Appropriate places for kids/families to go.
- Lack of accessibility to sexual assault crisis centers due to lack of staff, distance, and lack of diversity in staff members.
- Decreased funding – sexual assault crisis centers, prevention money from Virginia legislators, and training for professionals.
- Lack of trained evaluators for sexual assault of children (no standards required for evaluators).
- Monetary compensation too much for victims vs. mental health and services (competing priorities) – still need both.
- Insufficient treatment for juvenile offenders.
- Limited treatment options for offenders.
- Providing treatment to victims and offenders: Lack of local service providers and transportation, lack of money and or insurance, lack of awareness of need for treatment, lack of available/affordable intensive treatment programs for offenders (juveniles and adults), lack of services to family members and parents.
- Victims don't know where services are and how to access them.
- Waiting lists for counseling services.
- Lack of identified “safe places” for disclosure.
- Lack of sexual violence advocates from local agencies for hospital accompaniment and follow up support.
- Lack of time, money, management and support for sexual assault programs/teams in hospitals (see more people).
- Transportation issues for victims accessing services – court follow up care, hospital, sexual violence program.
- After care follow up with victim after crisis – local programs need to be brought in (referrals) ongoing support.
- Free clinics don't have SANEs.
- Insurance for mental health treatment.
- Lack of facilities/privacy to do PERK in ERs – room or building, storage of evidence.
- Lack of follow up facilities – access to services for HIV/STI referrals re: medications, counseling, re testing.
- No funding for emergency contraception and HIV prophylaxis.
- Poor crisis response – too much reliance on volunteers, poor funding, soft \$, high staff turnover – burnout and lack of consistency.
- State coverage 1<sup>st</sup> follow up visit.
- Hospitals – lack SANE/FNE program, also required to serve as floor nurse, on-call responsible, emergency services (poor training), triage of sexual assault, lack of dedicated space.
- Lack of availability of mental health services for victims in community.
- Limited mental health resources.

### **Inconsistency of victim services availability across jurisdictions**

- Disparity of services between areas.
- Lack of consistency in sexual offender registry as doesn't include all sexual felonies.
- Accountability – juveniles aren't held accountable by the system and society "Boys will be boys" mentality.
- Rape crisis response inconsistent in some areas – need accountability.
- No recommendations/consistent protocols on how to handle these cases.
- Lack of consistency and politics (different agencies have different ways of responding to victim) between agencies in communication.
- Standardization of local certified sexual assault programs.
- No consistent protocols, jurisdictions, attitudes.
- No requirement to have SANE on staff or available to hospitals by Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- Inconsistent responses – good and bad cops.
- State Adult Protective Services (APS) policy – passes bucks (policy very open to interpretation, if person is raped in adult home and they are admitted to hospital, APS does not have to open a case – victim is "safe" – it is a licensing issue, not a service issue).

### **There is a lack of formal communication or coordination between service providers**

- Need for network across professional lines (MDs, Ph. Ds, social workers, pediatricians, teachers).
- Review competency to serve – more than just abuse/neglect criteria, open access to mental hospital services and consequences to appropriate circumstances.
- Inappropriate placement in mental health or juvenile detention.
- Not enough effective intervention for perpetrators – not enough research/knowledge of what will be effective.
- No tracking of victims by CPS.
- Failure to comply with mandatory reporting – EMS not required to report.
- Recognition of Parental Alienation – syndrome by courts (bogus "diagnosis") that allows perpetrator access to victim.
- Lack of recognition of cost effectiveness related to early intervention and treatment.
- Confidential policies of agencies during Multi-Disciplinary Team (MDT) meetings.
- No follow-ups by agencies or communication about what each agency is doing.
- Separate investigations by police and CPS.
- Lack of commitment by local programs (to focus real money on prevention when times are tight, cut the public education budget!).
- Turf issues between agencies competing for funding, etc.
- Lack of communication between agencies (hospitals, local domestic violence and sexual assault, law enforcement, mental health).
- Need for coordination of SART (leadership, time, staff).

- Lack of coordination of response.
- Health Insurance Portability and Accountability Act (HIPPA) guidelines – continued issues, prevents sharing of information or calling advocates.

**Some service providers do not receive training in how to respond effectively to victims of sexual assault**

- Lack of training for allied professionals such as: Law Enforcement, Court Personnel, Mental Health, School Personnel, Faith Communities, etc.
- Mental health, substance abuse, medical facility staff not trained to do sexual assault screening on routine basis.
- Lack of recognition by law enforcement, mental health, other professionals and community members that mental health problems are highly correlated with a history of sexual abuse.
- Prevention: Lack of training (lack of opportunity for training, lack of motivation to go to training, lack of funding for specialized trainings).
- Training: communicate victim, building a criminal case (corroboration of victim's story); communicate with defendant, attitude toward sexual assault cases, procedures in handling cases in department.
- Training on how to work with victims.
- Insufficient knowledge/response by allied professionals responding to sexual violence (nurses, law enforcement, laws and protocol, resources available to victim).
- Not disseminating SART – training programs available are not being sent out/given to those who work in the field.
- Accountability by all professions on maintaining training, education on this issue.
- Lack of sufficiently trained experienced SANEs in community.
- Lack of awareness training re: Victim's issues and needs within law enforcement, medical, programs, prosecution, media community.
- Lack of trainers to train (victim advocates, nurses, law enforcement).
- Law enforcement training re: sexual assault inadequate – victim blaming, dominant paradigm = stranger rapes, evidence collection and investigation methods skewed towards stranger.
- Poorly trained medical staff – judgmental (lecture victim), male bias, blaming-decreases willingness to report.

**Other**

- Turn over/burnout.
- Lack of data on effectiveness of model programming to reduce sexual violence (funding issues).
- Lack of evidence-based models, lack of pre-college efforts, cultural barriers to construction of sexual and domestic abuse.
- Lack of commitment on behalf of general assembly to allocate resources to prevention.

## **Recommendations**

### **Increase prevention education programs in schools, colleges, and military facilities**

- Education on college campuses and military bases on date rape, healthy relationships, substance abuse including alcohol.
- Required education at high school/college level – Sexual abuse sign “How to have healthy sexual relationships”, Sexual assault hotline in all communities.
- Appropriate behaviors in health class – manners extended at all levels of interactions.
- At least one staff person on every college campus dedicated to sexual assault issues.
- Create replication model for peer education programs-start earlier.
- Cross-cultural targeted education efforts that demonstrate cultural sensitivity.
- Develop a curriculum for parents and early intervention, home visiting staff.
- Educate parents to monitor child access to internet and television with sexual and violent content – provide negative consequences to failure.
- Identifying “safe people” to talk about sexual violence issues (in schools, etc.).
- K-12 Education for preventing relationship violence and sexual assault.
- Mandate family life education for all schools – allow all topics to be discussed, allow correct terminology for sexual body parts, no “Opt Out” policy.
- Mandatory comprehensive sexuality education K12 – look at the European model.
- Mandatory research-based comprehensive (multi-session) programming in schools at all grade levels with reporting requirements that training has taken place (assessment of trainings).
- Mandatory research-based multi-session programming for students in all of state’s colleges/universities.
- Piggy Back education with other educational material information with birth control, cervical cancer awareness.
- Proactive measures to stop potential perpetrators from acting, teach people not to engage in abusive relationships.
- Promote new 3R’s, philosophy: Rights, Respect, and Responsibility.
- Remove political barriers to sexual education.
- Requiring school systems to provide a minimum number of hours for curriculum on prevention provided by community specialists – engaging DOE and school boards.
- Teach appropriate sexual behavior – “no” should be the norm not exception.
- Expanding primary prevention initiatives across the state – funding (current state prevention funding -\$0), identifying community needs and local points of delivery (sexual assault crisis centers) - Social sensitivity programs – K-12 education.
- Prevention initiatives statewide.

- Parenting skills to include education of children.
- Appropriate touching/media exposure.

### **Increase effective prosecution of offenders**

- Increase evidence based prosecution and investigation.
- More female investigators.
- Specialization (Commonwealth Attorneys (CAs) that specifically work sexual violence, detectives that specifically work sexual violence, etc.) following cases from beginning to end!
- Increase use of experts to explain victim response/behavior during and after sexual assault.
- Law enforcement officers should follow always, the protocol in place regarding polygraphing victims.
- Identify and isolate pedophiles (jail), research/outcome in reference to sex offender treatment programs.
- Accountability in this process above. Cases brought before the Commonwealth's and District Attorneys (CA/DA) vs. cases that actually make it to trial. Only record currently kept is cases tried.
- Court Watch programs statewide for sexual assault cases as well as domestic violence cases.
- Law enforcement must be more pro-active in requesting PERK results before court.
- Legislature requires judges to obtain certification in sexual assault issues on impact on victim.
- Mandatory reporting by schools, churches, organizations, etc. so that they cannot resign from their position and continue to work in positions of authority over children – including college students.
- No pleading down of a sexual crime against a child by the judicial system.
- Option of seeking a declaratory judgment against a Commonwealth Attorney who you feel has not held their oath of office.
- Require the state standards for mental health evaluators in court cases.
- Use of special grand jury system in felony cases provided as an option for victims.
- Use the California model for the complaint review forms, allows a pattern of perpetration to be recognized.
- Encourage increased reporting: provide support, building trust 1st to create foundation for reporting, education on prevalence, decrease victim-blaming, anonymous reporting as entry to formal reporting, and educate judges.
- "Community Court Watch" to provide accountability and develop more broadly (exists in Richmond).

### **Improve the ability to identify and track convicted offenders**

- Registry of persons who work with victims – college, high school, hospitals, CPS, social services, mental health contacts.
- All sexually related felonies should be required for registration in the sex offender registry.

**Be more responsive to the needs of the victim when investigating reports of sexual assault**

- Increase funding/implementation for housing and transportation.
- Non-judgmental investigating approach.
- One interview for victim.
- Reduce social stigma of being identified as victim by using media (PSA).
- Respectful attitudes and awareness training for law enforcement prosecutors.
- Investigation trained with true compassion and true concern.

**Expand availability of forensic nurse examiners**

- Develop SANE/FNE programs in rural areas, joint jurisdiction by CPS and prosecutor in child abuse, continued participation and following protocols in multi-disciplinary teams.
- 24/7 forensic services available in every ER in the state with appropriated funds.
- Establish SANE programs in all hospitals, Perk, physical evidence, recovery kits available for adults and children in all hospitals.
- Forensic Exams: All large trauma centers would have a forensic nurse at the facility 24/7 smaller facilities would have a plan for no more than 2-hour wait, police departments required to provide transportation to forensic nurse facility.
- Create full-time positions for FNE and SANE, rather than current on-call/part-time arrangement.
- Availability of SANE response within X miles or time from victim.
- Dedicated full-time FNE positions in hospitals.
- More funding to provide more staff to forensic lab which equals PERK kits processed more quickly.
- Trained SANE folks at free clinics.

**Increase the number of sexual assault centers**

- More victim advocacy centers to include; victim/witness, shelters, mental health counseling, law enforcement, social services, health department, legal advocacies, prosecutors, probation officers, doctors/nurses, specialization of workers in system – law enforcement officers (LEO), prosecutors, CPS, victim advocates.
- Adequate funding for more local shelters for victims and children of sex assault and domestic violence.
- Children's Advocacy Centers as model for collaboration in support of sexual assault victim (exists in California).
- Mentoring programs to promote collaboration with sexual assault survivors and sexual assault victims in the healing process.

**Provide consistent responses to victims**

- Funding to make programs such as Care for Kids, Delta, CAPP, etc. readily accessible in all communities (CAPP is a mandated program in New Jersey)
- Increase funding for sexual assault crisis and intervention services and transportation to these counties
- Program services need to be based on best-practices (documented results)
- Replicate Camp Mabon throughout state (currently only 12 people can be served a year). Virginia Sexual and Domestic Violence Action Alliance is the sponsor
- State funding for primary prevention at all sexual assault crisis centers – In 2006 a bill for 1.2 million for this was not successful
- Take model program (SART) statewide with appropriated \$\$ - training, etc.
- VDH Division of Injury and Violence Prevention throughout the state.
- Local, regional and statewide coordination of SART (at Homestead, VA Beach).
- Promulgate state-wide standards for crisis support and medical treatment and sexual assault providers.
- Standard of care for sexual assault victims.
- Standardization of sexual assault advocate programs – mandatory certification from Action Alliance.
- Standardized protocols for Victim Advocacy Response, law enforcement, prosecution, medical responses, local advocates.
- Uniform reporting form statewide for forensic nurses.
- Expanding coordinated community responses across Virginia – development of standards and protocols, training, funding.
- Promote routine screenings for sexual and domestic violence history in mental health, substance abuse and medical facilities.
- Utilization of child advocacy center/family justice center models (coordinated, one-stop shopping).
- Provide state funding for more than just Hugs and Kisses – expand funding to other promising programs such as CAP, Caring For Kids.
- Funding for Department of Mental Health and mandate insurance coverage for intervention programs for children who witness or are victims of violence.
- Provide educational/therapeutic services for family members of victims on local level to facilitate access to services and changes in family.
- Need coordinated community response team (CSA model) to set protocols and response.
- SART teams for all jurisdictions.
- Coordinated effort of tracking resources by regional coordinators filter to local level – Funding 5 regional coordinators for specialized teams on sex abuse/assault, increasing number of specialized individuals
- 2<sup>nd</sup> Responders available 24/7 to go out to crime scenes etc.
- Advocate based out of the ER.
- Create social worker positions in hospitals with special emphasis in sexual assault support.
- Increase diversity of staff and volunteers that work in this area including: race, gender, ethnicity, sexual orientation, etc.

- Mandate funding to create and implement local SARTs.
- Systems for “quality assurance” with sexual assault programs in order to obtain/maintain certification through Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) (not just self-report on survey, but letters of “recommendation” from police department, forensic nurses, other service providers).
- Use multi-disciplinary team for case management – support group for victim.
- Victim witness, CPS, Commonwealth Attorney, Law enforcement, Advocates.

**Increase data collection and analysis and identification of best practices**

- Better collection of data (forensic nurses not shown in Virginia data, neither is social services.)
- Identify effective planning frameworks that can be used to develop prevention initiatives in a given community – ensuring that those initiatives address sexual violence before it occurs and conditions in which individual attitudes and behaviors occur.
- Need research about what does work as intervention for perpetrators.
- More research based education programs in schools and colleges, programs incorporating alcohol education and its role in sex crimes, information gathering by educators in reference to the situation in their schools; identify most at risk victims, situations, suspects

**Require specialized training for service providers in responding to sexual violence**

- Specialized training for LEO, professionals in speaking to child victims (all victims) to increase success of prosecution.
- Increase awareness, training, coordination of first responders – law enforcement, teachers, doctors, EMS, prosecutors, probation officers.
- Increased availability of information and training about healthy sexual development and elements of abuse to parents (i.e., free classes provided by local healthy baby/child organizations)
- Support research and training for treatment professionals-creating incentives in schools of social work and psychology for people to work in this area
- Increase funding for specialized training for first responders on sex assault, domestic violence – EMS, law enforcement, prosecutors, victim/witness.
- University based education for those going into first responder professions for example, LEO, social work, counselors, legal.
- Education for lawyers, judges, teachers, physicians, therapists, education on signs and symptoms of abuse, particularly in children, education on barriers: legal, medical, physical (not available, distance to help).
- Appropriate training for new RNs and ongoing trainings as well - \$\$.
- Easier access/training on funding streams, \$\$ available.
- Educate judges about sexual assault and domestic violence to improve consistency on bench (rulings, sentencing).
- Magistrate education – sensitivity training.

- Mandatory training for allied professionals such as law enforcement, police academy and local law enforcement officers statewide, court personnel, mental health, school personnel, Commonwealth Attorney's Office – make training/education more available to faith communities.
- Mandatory training means initial and on-going training at the allied professional agencies listed above.
- Mandatory trainings for all local government agencies on sexual violence issues (directors, line staff, volunteers).
- Police education at basic level of violence – not wait until rape occurs.
- Promulgate understandings of rape trauma syndrome and its impact (judges, law enforcement, Commonwealth Attorney).
- Provide training for religious leaders/social support networks to respond to and where to refer victims of sexual violence.
- Special certification and incentives for prosecutors and law enforcement and school counselors, judges who work on sexual violence – i.e. Sexual Crimes Institute – recruiting people that want to work on these cases.
- Train law enforcement widely in investigation of acquaintance assault – by far more common than stranger assault.
- Educate prosecutors and law enforcement in reference to anatomy.
- Training those who implement prevention initiatives on promising practices.
- More sexual assault training available for police, community.

#### **Other**

- Counseling services for responders to sex assault to decrease burnout and maintain consistent involvement of some persons; prevent turnover.
- Continuing dialogue like today – resource list – Attorney General's office has domestic violence report.
- HIPPA exceptions for sexual violence advocate information sharing – medical staff can call advocates.
- Fees gathered from hospitals that refer patient.
- Shift funding focus to prevention/early intervention while NOT DECREASING funding in treatment/intervention sources.

## **Governor Kaine's Commission on Sexual Violence**

### **Tidewater Virginia Input Session Summary**

#### **Best Practices**

##### **Programs that raise public awareness and understanding of sexual assault**

- Community education – schools, health professionals, *Hugs and Kisses* program.
- Community outreach – workshops.
- Statewide public awareness – *Red Flag* campaign, white ribbon, *Art of Surviving*.
- Good community outreach education.
- Media involvement (getting better).
- Communities' involvement/committed to prevention efforts.

##### **Prevention education programs in public schools, colleges and universities and military bases**

- Early education – pre-school, Bad Touching program.
- Prevention: Education – date rape drugs, campuses, school (high school), males, crisis centers.
- Christopher Newport College, Thomas Nelson - sexual health week, Take Back the Night (Sexual Assault Awareness).
- Hampton University - health class, sexual violence education.
- Regent University – master's psychology class – sexual violence education.
- Old Dominion University/Tidewater Community College – Women's Centers – education about sexual violence.
- Education – prevention/awareness – middle/high schools and universities, agency trainings: state of the art prevention/treatment methods.
- Peer education i.e. Delta project.
- Prevention and education of at-risk populations i.e. athletes, incoming freshmen, middle/high schools.
- Education on college campus, education in military community.
- Education programs at Tidewater Community College for gender violence prevention, counselors available for students for crisis intervention and referral.

##### **Specially trained prosecutors and law enforcement personnel**

- Specialized prosecutors.
- Dedicated prosecutors in some communities.
- Prosecution of offenders specialized in area of sexual assault (prosecutors).
- Prosecution of all sexual assault cases regardless of relationship between offender and victim in Norfolk.

- Sexual assault detectives – more compassion towards victims.
- Willingness and ability to revise/research up to date status and policies.
- Awareness/flexibility with system changes.
- Specialized prosecution of child sexual assault cases, changes in military sexual assault policy (restricted reports).
- Specialized police defense.
- Presumption against bond 19.2 – 121 – protects victims.
- Norfolk PD very involved with victims and follow thru. More responsive, quicker response, better educated – evidence base.
- Keeping offenders in jail.
- Proper law enforcement of laws on the books trained law enforcement officers, law enforcement providing victim response information (positive).

#### **Availability and use of Sexual Assault Nurse Examiners (SANE)**

- SANE and FNE.
- Forensic workers.
- SANE nurses/companion program – Physical Evidence Recovery Kits (PERK), court advocacy, counseling.
- Free standing SANE programs.
- SANE/advocates.
- Companion service at SANE exam.
- Established forensic program with Norfolk – educated nurses on call 24/7.
- Response available, timely and excellent working relationships with Forensic Nurse Examiners (FNE) and victims.
- Good response/nurses interested in FNE.
- Experienced SANE nurse as expert witness.
- Sentara Norfolk general hospital support for SANE program.
- Forensic nurses response (SANE/SAFE).

#### **Victim advocates and victim witness programs to support victims of sexual assault**

- Victim witness program – kids in court cases, continuous contact, offer counseling and Criminal Injuries Compensation Fund (CICF), personal interviews, personal advocates.
- Victim advocates/witnesses available to provide support.
- Trusting relationship, one-on-one with a consistent person providing advocate/counseling.
- Victim advocates (as liaisons across the board).
- Victims witness advocacy.
- Legislative advocacy – voices/concerns being heard.
- All the work of Virginia Sexual and Domestic Violence Action Alliance (VSDVAA).
- Legislative advocacies – Action Alliance.

**Short- and long-term victim counseling and support services**

- Different therapeutic services – verbal, expressive therapies – art/music/dance, Eye Movement Desensitization Reprocessing (EMDR) therapy, group/individual counseling.
- CDC guidelines to offer testing (HIV) at office visits for any female 13-64 (we think it should be all inclusive).
- Serving secondary victims – decrease vicarious trauma.
- Counseling, therapy, support groups.
- Updated comfortable facilities – WHH foundation funding for capitol improvements, collaboration grant projects.
- Varied therapeutic services used to help victims i.e. Art Therapy, EMDR.
- Victim compensation fund.
- Providing free sexually transmitted disease testing and sometimes free medicine.
- Legal aid, safe programs, support advocacy.
- Competent psychological experts – to testify in court.
- Pre and post treatment based on assault, sexually transmitted diseases (STDs), pregnancy, follow-up, morning after pill.

**Emergency shelters and housing assistance for victims**

- Emergency shelters available – HER, Response Samaritan House, YWCA.
- Aftercare services for shelter participants.
- Transitional housing services.
- Providing emergency shelter/funding for hotel rooms.

**24-hour hotlines and emergency response services**

- Hotlines – HER, Response Samaritan House, YWCA – 24 hour live staffed.
- We now have more facilities, crisis intervention, sexual assault and crisis centers.
- Sexual assault resources available.
- Statewide and local 24 hour hotlines – immediate services – long-term needs
- Hotline referrals and support.
- Hotline – great referrals, crisis intervention.
- Local rape crisis center, Norfolk.
- Intervention: Programs to service victims, women's shelters, VISSTA.
- YWCA response providing immediate victim support and follow-up services and referrals/SANE program.
- Response – crisis counseling.
- 24/7 availability of first responders – one phone number (cell phones).
- Sexual assault advocates, PERK exams, SART teams, police in emergency rooms.

**Services specifically designed to meet the needs of children**

- Child advocacy centers.
- Child abuse program (Multiple response team) operated by Children's Hospital of the King's Daughters

- Medical, children's therapeutic services available for child sexual abuse
- Primary child abuse prevention program i.e. Healthy Families.
- Child abuse center (forensic model) – variety of services together.

### **Sexual Assault Response Teams (SART)**

- Sexual assault response teams.
- Potential of SART
- SART teams – facilitates communication across and between agencies
- SART (sexual assault response teams) – intercollegiate SART.
- Sexual assault response coordinators (SARC), military.
- Sexual assault response teams – SART – quarterly meetings, collaboration between agencies, monthly meetings within agencies (military).

### **Collaboration across agencies and facilities for the benefit of victims of sexual assault**

- Domestic violence task force.
- Inter-agency collaborations – hospitals – building relationships, building collaboration with CSB, social services, Health department.
- Board of health professions is now responding to cases of alleged sexual assault by medical health professions.
- Virginia Beach police cooperative with agencies i.e. ride along programs with Samaritan House, client referrals.
- Cooperation amongst agencies i.e. shelters able to provide services to multiple cities.
- Efforts to improve communication and cooperation between military and civilian entities i.e. military liaisons in court, military/civilian task force.
- Relationships established and working well – commonwealth attorney, victim witness.
- Shared experts for training from other disciplines and agencies.
- Inter-agency dialogues re: prevention.

### **Training for service providers on effective responses to victims of sexual violence**

- Certification for trained professionals and therapists for sex offenders.
- Education for Sexual Assault Nurse Examiners (SANE), doctors and emergency room (ER) staff, standard treatments/protocols, educational standards (SANE, ER department staff).
- Training through Department of Health and Human Services.
- Police/ER/college trainings – connection between agencies and universities.
- Education – relationship seminars, education to social workers about domestic violence.
- Hampton Police – training to educate about sexual violence, first responders training (like to expand).
- Training – military advocates, volunteer advocate curriculum.
- Special victim unit - knowledge and special training.

- Training geared towards specific audience – age, gender, leadership, supervisors.
- Training for offenders – victim impact – seeing a victim in person.

**Blind or anonymous reporting**

- Blind reporting option.
- Anonymous reporting (Not blind reporting – reporting at colleges for referrals, response of the YWCA; statistics).
- Restricted reporting options for military members – blind reporting.

**Other**

- Crime lab quality feedback and education (DNA test results).
- Private physician screening for domestic violence (sexual violence falls into this category) – Virginia Beach department of Human Services/Social Services, screening form (6 questions).
- Traveler aid i.e. provides bus transport for relocation.
- No billing for PERK.
- General Hospital.
- Hospital based program for medical treatment.
- Statewide data collection: Virginia data.
- Non-profit services – free services for the community.

## **Barriers**

### **Public education and community awareness programs are not in place in all communities**

- Lack of education in community, i.e. police, teachers, parents about sexual assault.
- Parents not monitoring what children are exposed to – need more education for parents on what to be aware of.
- Lack of knowledge/training from K-college (educational system). Domestic violence and sexual assault (faculty and student).
- Community education – how to reach community with no ties to legal, treatment services, prevention.
- Funding for community education – grant funds drying up, grants are more restrictive.
- Prevention education – less staff funding, getting education into the school systems.
- Victims – unaware of rights and services available to them.
- Education/awareness of alcohol facilitated assaults.
- Knowledge of available after-care and counseling.
- Lack of public awareness/visibility – what is sexual assault?
- Lack of mandatory education – secondary schools and university levels (parent and peer education).
- Lack of public education (changing society's views).

### **Reluctance to investigate and prosecute all instances of sexual violence**

- Lack of adherence to Virginia established Sexual Standards of Care, (IFAN)- International Forensic Association of Nurses.
- Law enforcement specialization – resistance of personnel, officers don't want to work these cases, lack of personnel.
- Lack of participation by first responder/law enforcement in local task forces, etc. to address issues.
- Political nature of prosecutors (reluctance to prosecute cases unless they are "certified winners").
- Lack of specialized prosecutors.
- No crime scene investigation.
- Sexual assault cases need to be treated as a crime: search warrants, thorough crime scene investigation, unannounced interviews of alleged offenders, careful collection of evidence, investigations performed by trained professionals in sexual assaults, not Guardians Ad Litem (GAL), not custody evaluators.
- Protect victims (and crime scenes) even with preponderance of evidence.
- Bureaucracy.
- Police department, outdated stereotypes, throughout legislators/public office.

**Victims are sometimes treated with suspicion when reporting sexual violence**

- Polygraph of victims – reinvestigation.
- No trust/respect in system – system victimizations, bureaucracy, re-victimization, not believing.
- Lack of sensitivity (police, judicial system, community).
- System re-victimizes.
- Rights of victims sacrificed to meet the burden of proof.
- Blame the victim attitudes of law enforcement and society – re-victimization.
- Blaming the victim/punished for trauma.
- Collateral misconduct (blame the victims) (prioritize the crime).
- Negative effect of false reports of victims and some law enforcement.
- Same sex assault, not taken seriously, not reported due to stigma.
- Dysfunctional victim bias – victim blaming, “Why didn’t she leave?”
- Attitudes – blaming victim, religious views.
- System wide bias against any sexual assaults in custody cases.

**Not all victims are willing to report instances of sexual assault**

- Victims’ reluctance to come forward.
- Victims fear of not being taken seriously.
- Underreporting due to: fear of retaliation from offender; don’t know how to report/procedure, being ostracized by family (if offender is familial), economic loss (if familial), loss of the relationship (intimate partner situation), denial that everything has happened from either victim or family members, distrust of the system (law enforcement and the entire criminal justice process).
- Victim: fear, shame, guilt, lack of education and resources, lifestyle (ex. Drug users, prostitutes, homeless) cultures (ex. Some ethnicities that do not report).
- Fear.
- Identification of victims – all victims do not report, cultural norms, false reporting/partially false (not the whole story withholding portions of story).
- Fear of coming forward/reappraisal – stigmatization from friends, family and community, fear of being charged with another crime like under-age drinking, victim blaming and not being believed, re-traumatize through PERK, legal system and police questioning, losing income.
- Gender – males less likely to report.
- Child reporting incident to several persons, i.e. police, social services, etc. is traumatic.

**Some segments of the population have additional barriers to reporting sexual violence and seeking services**

- Cultural barriers (understanding of cultural differences).
- Language barriers.
- Mental health status of victim (being able to articulate what happened).
- Prison system – more likely not to report (males or females), guards/personnel-victimizing inmates.
- Children victims – mom working with perpetrator, mom does not believe child, child not believed in court, child confused by defense attorney, child intimidated

by defendant.

- Cultural sensitivity (practices).
- Illegal aliens (cultural immigrations) – strong networks that protect defendants, language.
- Child Protective Services (CPS) – unfounded = doesn't mean it didn't happen, CPS stops when defendant claims he did not do it.
- Language/cultural barriers – difficulties communicating.
- Community isolation.
- Special population's: males, elderly.
- Underserved/special populations/marginalized – disabilities, males, elderly, children, cultural considerations (language barriers, religions, immigration).
- Availability of translators, including sign language.
- No services for non-English speaking victims (translation, understanding of special needs/cultural).

**Absence of statewide standards contributes to inconsistent responses to victims across jurisdictions**

- Inconsistently offered services for follow-up care in hospitals.
- Consistency of police response.
- Criminal justice process and legislation – lack of consistency in prosecution – standardization.
- Standardized laws across the states.
- Law enforcement protocols and policies – lack consistency.
- Uniformity – there is a lack of/gaps in services available.
- Apathy – not taking time, no protocols on how to work, un-enforced laws/protocols.
- Standard protocols – lack of privacy (ER waiting room).
- Standardized assessments/interviews (PERKS).
- Distribution of funding – populations vs. services provided – rural areas.
- Judicial system, i.e. inconsistency in handling violence cases.

**Public reluctance to discuss sexual assault contributes to a poor understand of the issues and a negative stigma for victims**

- Misconceptions of perpetrators.
- Stigmas attached to sexes, gender bias.
- Stigma of being “damaged goods” after being raped.
- Societal myths concerning sexual assault.
- Society's perception of the victim given the circumstances – re-victimization.
- Stereotypes of gender.
- Rape culture – societal influences: desensitization though media/music/video games/traditional gender roles, racism and victim blaming.
- Media, sex in media, making sexual assault okay in society – video games (get points for raping women), sexual innuendos in movies, to commercials, in music.
- Self-perception based on media hype glorifies sexuality (being someone's “bitch”).

- Community attitudes – how a victim should act, learn from TV.
- Media coverage – lack victim sensitivity.
- Unawareness.
- Ignorance.
- Denial – “Sexual violence doesn’t happen here”.
- Religious views – believes “women as property”.
- Stigma – denial/unwillingness to speak about sex. “Rape Culture”. Society attitude that it is ok for violence against women to happen.
- Attitudes/judgment of society.

**Availability of services is inadequate to meet victim needs**

- No funding to protect children in civil cases.
- Limited access to case management/therapeutic services or medical services
- Lack of funding – misunderstanding domestic violence and sexual assault and how they relate, misunderstanding that domestic violence funding covers sexual assault funding
- No funding for prevention – not always a priority (sexual violence misunderstood)
- Not enough research/data/outcomes on prevention studies
- Barriers to accessing treatment
- Staffing (not enough coverage)
- Necessary follow-up not taking place due to lack of funds
- Lack of treatment facilities for victims
- Lack of services for detention centers on domestic and sexual violence
- Lack of funding to pay staff, to train student, faculty and staff in sexual assault and domestic violence prevention and treatment
- Lack of treatment in correctional system, for assault victims
- Child Abuse Center, no self referrals, only through human services and law enforcement
- Services to victims – limited if not reported to law enforcement
- Lack of money for: SANE nurses, prevention, advanced training for law enforcement, public service announcements
- Agencies are all under-staffed (sexual assault detectives, SANE sexual assault crisis centers)
- Hospitals reluctant to take on SANE programs – lack of support for stand alone programs
- Crime lab protocols for looking at evidence due to the increased kits – understaffed
- Satellite facilities (doc in the box) ex. Patient First
- Transportation for services.
- No/limited resources/services for victims – lack of transportation to get services and no reliable child care.
- Money to pay for medical care and testing.
- Expense to victims – emotionally, financially (cost of exams, attorneys, time off from work, transportation and prescriptions).
- Cost reimbursement for exams (PERK) not reflective of actual cost (medication,

equipment, expert witness, etc.).

**Service providers not communicating across systems to provide a coordinated response to victims of sexual violence**

- Communication between systems involved.
- Collaboration with different agencies/law enforcement (medical providers, referrals).
- No communication within law, medical, victim and other workers.
- Communication and coordination of services.
- Lack of communication between legal, police, victim and victim witness.
- Lack of referral system between public agencies.
- Lack of cooperation from law enforcement agency and hospitals.
- Lack of cooperation/communication between agencies.

**Not all service providers receive training in how to effectively respond to victims of sexual assault**

- Unaware of reporting laws (physicians).
- Law enforcement lack training in what is best for victim.
- Judges, prosecutors, law enforcement, victim advocates need prevention training.
- Lack of advanced training for detectives.
- Not enough training (law enforcement/commonwealth attorney's/judges/lawyers).
- Lack of adequate funding to train health care providers (ex, emergency room personnel, Includes law enforcement).
- Not enough education to community, schools, legal, law, medical, treatment, social services, etc.
- Lack of services/awareness/training.
- Need for better training for social services and CSB.
- Lack of trained clinicians (misdiagnosing, re-traumatizing, especially with children and teens).
- Responding effectively to victims.
- Conflict of interests – untrained and unprepared staff, attorneys, police, social workers, judges, doctors, therapists and first responders.

**Insufficient awareness and support by elected officials**

- Local politics.
- Funding lack there off (politics).
- Legislation – don't have this - No Means No legislation, legislation that is all inclusive for all types of sexual assault, legislation that specifies funding for sexual violence and prevention.
- Lack of empowerment to make change and influence policy – speaking with legislators, speaking to community civic leagues, speaking with law enforcement and church/faitb based groups.
- Lack of awareness of state officials on state education guidelines for forensic nurses.

**Other**

- Blind reporting creating a stress on agencies/resources (storage of PERK kits, staffing issues).
- False accusations – snowball effect and myth of number of false accusations.
- Burn-out (nurses, detectives, crisis center staff).
- Sex Offender Registry – not up to date, civil offenders (DSS) are exempt from registry.
- Gang initiations – prospective member is “sexed in”.
- Sexual assault happening on cruise ships (or overseas).

## **Recommendations**

### **Increase state efforts to prevent and address sexual assault**

- Make sexual assault prevention and responses a real priority – action, funding, not just talk, i.e., Department of Defense (mandated).
- Disaster prevention planning must include rape prevention component (ex. Superdome in New Orleans).
- More grant programs to encourage agencies with best practices.
- Financial commitment.
- Increased funding for programs for children impacted by sexual violence.
- State funding for prevention work regarding sexual violence directly to SARTs without all the paperwork of grants.
- Educate state officials on educational requirements for forensic nurses.
- Educate state officials on standards of care for sexual assault victims.
- Creation of a sexual violence/assault office in Richmond (state government).

### **Provide sexual violence prevention education in all public schools**

- Increased/mandatory prevention education, re: sexual assault in schools (k-12).
- Education within public schools and pre-schools.
- Bad Touch Training for all ages of children (free coloring books).
- Increased funding for prevention education in schools and the community.
- State wide education/media campaign during April, sexual violence awareness – target college community.
- More funding, especially for violence prevention for all ages, even pre-school, elementary schools and colleges, military (peer education).
- “Curriculum infusion” in all educational settings, re: violence prevention (mandatory).
- Teen community training peers about sexual violence and self esteem training.
- Increase awareness of gang violence to public school students.
- Beginning education about sexual violence at younger age.
- In-school education team – with police, first responders (collaboration) to teach children – middle school physical education – about sexual assault, date rape.
- Training in high school towards potential victims and potential offenders (what is sexual assault?).

### **Provide sexual violence prevention education in colleges and universities**

- Higher level education.
- Higher education - require sexual violence prevention education – to be included in new student orientation.
- Tidewater Community College TCC required annual sexual violence and sexual misconduct prevention education and training for faculty and administration.
- College campuses – satellite facilities, specialized personnel on campus, increase security.

**Increase public knowledge and awareness regarding issues surrounding sexual assault**

- Public awareness campaign re: sexual assault.
- Change assumptions, re: gender assumptions in society, to dismantle gender-socialization.
- Change societal attitudes so people see emotional abuse as very important (sexual violence is not just about sex: it's about power and control).
- Funding and education for faith communities and other community groups, e.g. workplace, recreation centers, etc.
- Parent program on education of media violence.
- Involving civic/community leagues in dialoguing and supporting awareness of sexual violence.
- Back to the basics: speaking to civic groups, churches schools, etc., college students, businesses.
- Public service announcements (education) in the media (T.V., radio, etc).
- Statewide prevention campaign – coordinate Sexual Assault Awareness Month (April).
- Ad campaigns – national level, state and local – “No Means No” legislation.
- Public awareness – brochures, flyers, posters, all types of advertising, diverse distribution sites.
- Brochures in all health profession offices, re: sexual violence/referrals to services.

**Increase efforts to prosecute and punish all convicted offenders**

- More aggressive prosecution of cases (that may not have a guarantee of conviction).
- Consistency in sentencing.
- More public records regarding sexual assault cases (how many cases reported vs. prosecution and outcome) – report card.
- Mandatory investigation of offender.
- Specialization to handle these cases, i.e. detectives, prosecutors, victim advocates, etc.
- Regional highly trained teams to include: attorney for victim (especially child victim), law enforcement, social worker, forensic specialist, to properly and quickly collect evidence and avoid taint.
- Specialized law enforcement career field to work with sexual assault cases (stop drawing straws)
- Commonwealth Attorney determines location of PERK (to maintain quality of evidence and testimony).

**Reform existing laws to increase penalties for perpetrators and better meet the needs of victims**

- Education and legislation to deal with abuse over the internet.
- Legislation for mandatory reporting (especially in medical facilities) of sexual violence.

- Change Virginia statutes so convicted rapists (like prison guards) are not allowed to have visitation rights (like other convicted sexual felons) and so these rapists are included in the Sex Offender Registry.
- Change laws so institutions are also liable for sexual abuse (i.e. churches when priests offended).
- Attorney General mandates to Commonwealth Attorneys incorporating BLIND reporting as a standard of practice.
- Specific wording to be all-inclusive to cover all types of sexual violence and degrees of assault.
- Change Sexual Battery Statute to remove force, threat, intimidation.
- Better laws to prevent re-victimization, e.g. no lie detector tests for victims.
- Changes statute of limitation so you have more than two years to report sexual abuse after you recognize you've been abused.

### **Expand the continuum of care for victims of sexual assault**

- Developing easier and more memorable hotline number.
- Less money spent on tracking sexual offenders with email, bracelets, GPS tracking – priority should be on public awareness, prevention and intervention and services to victims.
- Increased funding for case management – money for crisis intervention, after-care services for persons in need.
- Establishment of safe houses where victim can go.
- Funding for facilities' improvement, PERK exam rooms and counseling rooms.
- Financial assistance with transportation, childcare, housing, food.
- Greater access to counseling, support groups.
- Follow-up/after-care of victims.
- Support for victims post-release of offenders.
- Broaden eligibility requirements to ensure victim's family members and offenders receive community services (whole person concept).
- Safe houses (facilities), ex. therapeutic treatment homes.
- Increased money to adequately staff agencies.

### **Increase victim advocacy programs**

- Funding for sexual violence advocates working in police stations to support victims as soon as they walk in the door, and accompany victims as an active advocate throughout the whole process.
- Develop sexual violence advocacy centers (similar to child advocacy centers).
- Follow-up with victims, re: how we can improve, do the job better, etc. – evaluation tool (phone, writing).
- Advocate for everyone early on, notification of crimes, etc.

### **Develop programs and mechanisms designed to address the unique needs of specific segments of the population**

- Work on "gang issue" because rape is now used as an initiation ritual.
- More funding to work with the special, marginalized/underserved populations in Virginia (see Barriers list).

- Outreach to senior community, i.e. elder care abuse resource for volunteers.
- More prevention programs for males.
- Comprehensive services for children who have witnessed violence – 60% of all children witnesses become abusers and a high percentage of female witnesses choose abusers as mates.

**Develop standards and systems that establish consistent responses to victims of sexual assault across jurisdictions.**

- Cross jurisdictional reporting of incidents and offenders.
- Providing a standard of care for those who have been sexually assaulted.
- Better compliance with campus violence established initiatives with sanctions for non-compliance.
- Universal law enforcement, sexual assault policies and procedures across the state.
- National protocol for servicing victims of sexual violence.
- Consequences for non-adherence to policy.
- Enforcement of existing sexual violence protocols at all-levels.
- Mandatory that first responders have resource cards to give to victim (include community resources such as treatment options, medical, legal, etc).

**Increase funding sources to support services for victims**

- Use seized evidence (such as funds, auction revenue) to fund rape crisis centers.
- Taxes on pornography to go towards funding rape crisis centers.
- Corporate sponsorship (involvement), re: sexual assault issues, education (especially pharmaceutical or alcohol similar to drunk driving campaigns).

**Establish multi-disciplinary teams to respond to incidences of sexual assault**

- Inter-agency (mandated) SART teams, in preparation for court.
- Establish SART teams with each jurisdiction.
- Large SANE programs vs. lots of small programs (better evidence and more experience).
- Coroners to allow observation of autopsy (required for SANE).

**Increase collaboration and communication across agencies and service providers**

- Increased/continual communication/dialogue with/between stakeholders (police, schools, colleges, community groups, hospitals, Commonwealth's Attorney, local government – more of this).
- Collaborative efforts with Portsmouth, Suffolk, Chesapeake and Virginia Beach Law Enforcement incorporating best practice and adherence to state standards of care for assault victims.
- Forensic nurses collaborate with police department to educate new rookies and continual education to officers on services available to patients and benefits of collection of evidence PERK kits for successful prosecution.

**Increase sexual assault training opportunities and establish required levels of training for professionals throughout the response system**

- Education: police need funding for specialized training.
- Training: for teachers/education professionals, early childhood education (continuing through high school and college) – for date rapes.
- Increase training for law enforcement, medical providers (universal) mandatory; requirement of job.
- Judges, social intelligence training (trauma responses to sexual violence).
- Increased education in sexual violence issues for police, judicial system, social services, medical field, therapists, shelter staff and advocates – mandatory annual training (research based, consistent training for their field, provided by qualified staff, i.e. local rape crisis centers).
- Training for foster parents and recruit more therapeutic foster parents.
- Required coursework for legal, medical professions on sexual violence, Department of Social Services, Community Services Boards.
- Funds to train sexual assault crisis center workers and allied professionals.
- Mandatory sexual assault training for judges, lawyers, law enforcement, etc.
- Advanced training for first responders (i.e.-patrol officers and rescue personnel).
- Providing sensitivity training and multicultural awareness among people providing services to sexual assault victims.
- Training medical personnel to interview for abuse and to be made aware of the reporting laws.
- Funding for education/prevention to increase staffing for community outreach to include primary prevention at elementary school level.
- Training for First Responders/law enforcement to include role plays, test, etc. – budgets to include training.
- Crime lab education across state (evidence quality, recommendations, etc) – allows dialogue between crime lab and other agencies.
- Training for first responders, police, fire fighters, emergency medical technicians, medical personnel.
- Mandatory sexual assault training for offenders in correctional facilities.
- Funding or tax relief for mandatory continuing education units for SANE.
- Expand educational programs for beauty schools on sexual and domestic violence.

**Improve data storage and information systems**

- Storing DNA in database.
- Sharing of offender database between states (interconnectivity).

**Establish support programs for sexual violence service providers**

- Support services for sexual violence workers (worker support groups).
- More funding to support sexual violence workers to prevent burnout/vicarious trauma.
- Security lights and locks for under privileged populations.

**Other**

- New Zealand is good role model.
- Practice “best interest of the child” if sexual violence is suspected (due to some organizations wanting to keep families together).
- Shopping Malls – increased security/surveillance.
- Enforcing age appropriate purchasing of media products, i.e. video games, internet, movies, TV, music.
- Coursework in all college counseling, psychology, MSW programs on sexual violence assessment and treatment.
- Support federal funding/policy to put more focus on societal causes of sexual violence rather than individual pathology.